Wellness

Annual Report 2001-2002

Healthy Child Development

Prince Edward Island
CANADA

Health and Social Services

103-05686/

Annual Report

for the year ending March 31, 2002

Ministry of Health and Social Services

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The primary purpose of this report is to provide Government and taxpayers with an account of the performance of the Department of Health and Social Services and the health system in general. This report will serve as a historical record, and as a vehicle to provide information on a very large and complex system which includes the Department and the five Health Regions of West Prince, East Prince, Queens, Southern Kings and Eastern Kings.

Each of the Health Regions also produces an annual report which focuses on activities, accomplishments, and initiatives specific to the region, and provides further accountability to Government and to the residents served.

Message from the Minister

To the Honourable J. Léonce Bernard
Lieutenant Governor of Prince Edward Island

May It Please Your Honour:

It is my privilege to present the Annual Report of the Ministry of Health and Social Services for the fiscal year ended March 31, 2002.

Respectively submitted,

Jamie Ballem

Jamie Ballem
Minister of Health and Social Services

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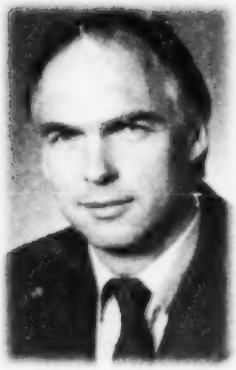
Deputy Minister's Overview



The Honourable Jamie Ballem
Minister of Health and Social Services
Province of Prince Edward Island

Honourable Minister:

It is my pleasure to submit the 2001-2002 Annual Report for the Health and Social Services System. The Annual Report is intended to focus on accountability for results achieved during the fiscal year. This approach in measuring and reporting on performance and outcomes supports one of the guiding principles in the Strategic Plan of the Health and Social Services System.

A few of the System's accomplishments and activities I wish to highlight are as follows:

a) A comprehensive strategic plan to guide the Health and Social Services System over the next 3-5 years is being implemented. The plan identifies several areas where we want to significantly improve our results: health status; personal responsibility for health; sustainability; public confidence; and workplace wellness and staff morale.

b) Our five Health Regions were awarded accredited status by the Canadian Council on Health Services Accreditation.

c) Construction of the new Prince County Hospital began. The new facility is expected to be completed and occupied in the Fall of 2003.

d) PEI became the first province in Canada to separate disability supports from income support programming (Welfare Assistance Programs) with a new Disability Support Program.

e) A national agreement to establish a single, common review process for new drugs supports the position taken by the Atlantic provinces to ensure a common Atlantic decision on new drug listings.

f) Our Health System balanced its budget for 2001-02, achieving a small surplus.

During the year our department employees, our partners in the Health Regions, physicians and other providers displayed dedication, commitment and professionalism in fulfilling their responsibilities and providing high quality health and social services for Islanders. We have a truly great team of professionals working with Islanders to improve our health and well-being. Islanders can take pride in our collective achievements.

Respectively submitted,

Rory Francis
Deputy Minister

Year in Review

STRATEGY IMPLEMENTATION

In December 2001, Government released a comprehensive five-year strategic plan for health and social services. Based on extensive consultation with providers and the public, the strategic plan provides a framework for the system to improve the health of Islanders and the performance of the system over the five-year period 2001-2005.

GOALS

The plan identifies six goals, or areas where the system wants to significantly improve results:

- Improve health status
- Increase individual responsibility for health
- Improve the sustainability of the system
- Increase public confidence in the system
- Improve workplace wellness and staff morale
- Maintain other results at current levels

Progress towards these goals during 2001-2002 is reported based on indicators of health status, health outcomes and service quality.

At the official release of the strategic plan, East Prince Health Board Chair Katherine Kelly speaks to the benefits of system-wide strategic planning. Looking on are Regional Board Chairs (left to right) Michael Gallant, Southern Kings; Westie Rose, Eastern Kings; Sylvia Poirier, Queens; and Robbie Thibodeau, West Prince.

STRATEGIES

The plan also identifies six strategies which outline the direction the system will take to improve its desired results:

- Wellness
- Healthy child development
- Access to services
- Human resources
- Information technology
- Partnerships to address the determinants of health

Progress to implement the strategies during 2001-2002 is also reported in this section of this report.

Wellness Initiatives

STRATEGY FOR HEALTHY LIVING

A tremendous amount of momentum was built in 2001-2002 to support healthy living in Prince Edward Island.

- Several strategic initiatives were implemented to increase public awareness and understanding of the risk factors for chronic disease; the impact of chronic disease on our health and health system; and the fact that many chronic diseases are preventable.

- A provincial Strategy for Healthy Living was drafted by the Public Health and Evaluation Division in partnership with other provincial government departments, non-government organizations, and community alliances dedicated to tobacco reduction, healthy eating and active living. As part of this strategy, partnership initiatives will be implemented to promote healthy living and prevent chronic disease. In addition, resources will be dedicated to chronic disease management within the health care system by collaborative interdisciplinary teams.

- Substantial new investments were made in the development of a new diabetes care, education and disease management model to prevent and reduce complications from diabetes which is occurring in epidemic proportions.

CERVICAL CANCER PREVENTION

Several initiatives were implemented to increase awareness that cervical cancer is preventable, and to improve access to Pap screening services.

- PEI's first Pap screening clinic was established in September 2001. Women can call the clinic in Cornwall directly for an appointment to be screened by a trained nurse, or they may continue to be screened by their family physician.

- A social marketing campaign to increase public awareness of the importance of cancer screening was conducted by the Department of Health and Social Services, the Medical Society and the PEI Division of the Canadian Cancer Society. The campaign used a variety of media to encourage women to accept responsibility to be regularly screened for cervical cancer.

Diane Devitt of the Canadian Cancer Society and Dr. David I. Stewart, along with Health and Social Services Minister Jamie Ballem respond to questions at the official opening of PEI's first Pap Screening Clinic in Cornwall.

TOBACCO REDUCTION

Health and Social Services staff continued to work in partnership with the PEI Tobacco Reduction Alliance (PETRA) on school-based prevention policies, access to smoking cessation programs and the promotion of smoke-free places.

- A major survey released in June 2001 indicated that 25 percent fewer Island youth smoked in 2000 than in 1999. The Canadian Tobacco Use Monitoring Survey (CTUMS) indicated that smoking rates among Island youth aged 15 to 19, fell from 28 percent to 21 percent in 2000.

- The Canadian Tobacco Use Monitoring Survey also indicated that fewer Island children are being exposed to second-hand smoke in their homes, with rates falling from 44 percent in 1996-1997 to 27 percent in 2000.

- Several school-based initiatives continued to be implemented during the year such as peer education programs where students talk to other students about the deadly effects of tobacco use; school-based smoking cessation programs; poster campaigns; and smoke-free policies in the schools.

- A Smoke-Free Homes campaign continued to protect people from second-hand smoke in the home. As part of the campaign, 20,000 decals were distributed to Islanders wishing to promote their home as smoke-free.

- Through a Smoke-Free Vehicles campaign launched in August 2001, Islanders were also encouraged and supported to make their vehicles smoke-free. Smoke-free vehicles signs were distributed through the Highway Safety Division, taxi companies and car dealers.

- A toll-free smoking cessation referral line was established in January 2001 to connect Islanders to community and government smoking cessation resources. Over 680 Islanders participated in the PEI Quit Smoking cessation counseling program offered through Addiction Services. Over 70 percent received assistance with medications to help them stop smoking. Of the 209 participants contacted three months after exiting the program, 31 percent were not smoking, which is much higher than the average success rate of 3 percent achieved by people who try to quit without assistance.

- During 2001-2002, initial steps were taken to draft provincial legislation to reduce smoking in public places. This included discussions with stakeholder groups and the preparation of first draft legislation.

HEALTH INFORMATION AND EDUCATION

The Health and Social Services System continues to provide Islanders with access to information to maintain and improve their health.

- During the year, the Health Information Resource Centre responded to more than 900 inquiries per month from Islanders looking for ways to improve their health or information on where to get help.
- A marketing campaign, launched in April, used radio commercials, business cards, brochures and posters to encourage Islanders to contact the Health Information Resource Centre for reliable health information.
- The Centre also facilitated several telephone help and information lines.
- Departmental staff continued to develop and distribute educational resources on topics such as nutrition and prenatal health.
- Workshops were coordinated to inform and engage the public and partner groups in strategies to address childhood obesity and harm reduction.

Healthy Child Development Initiatives

BREASTFEEDING

While PEI fares well on many indicators of child health, breastfeeding rates are lower in Atlantic Canada than other provinces. Several initiatives were implemented during the year to increase breastfeeding rates in Prince Edward Island, a priority area for action identified in the provincial Healthy Child Development Strategy.

- Health and Social Services staff worked with members of the PEI Breastfeeding Coalition to develop educational materials which promote breastfeeding as the cultural norm and ideal choice for infant feeding on PEI.

- A survey was developed on what helped and hindered breastfeeding. The survey will be conducted on women who breastfed their year-old child when the child is taken for their one-year immunization.

- More than twenty public health nurses participated in a certification course for health care providers who support breastfeeding mothers.

INTEGRATED AUTISM STRATEGY

In 2001-2002, Prince Edward Island made major new investments in early intervention services for children with autism.

- Early intensive behavioural interventions were offered to children with autism through the Applied Behavioural Analysis (ABA) program.

- The Department of Health and Social Services and the Department of Education collaborated on the development of an integrated autism strategy to ensure that supports for Autism Spectrum Disorder are directed in a planned and organized manner. The strategy recommends a case management approach by various professionals to meet the unique needs of children and families using a wide range of integrated supports such as medical, family, pre-school programs; and training of in-home workers, parents and therapists.

PROVINCIAL HEALTHY CHILD DEVELOPMENT STRATEGY

A great deal of developmental work occurred in the year 2001-2002 to support the provincial Healthy Child Development Strategy which was launched in 2000.

- An inventory of current PEI children's issues was developed to support the strategy.
- Roles and responsibilities were established for the Premier's Council On Healthy Child Development, the Children's Secretariat and the Children's Working Group.
- Prince Edward Island's first Think Tank on Children was held in November 2001, and an action plan was developed based on the priority direction identified at the Think Tank.
- The Premier's Council On Healthy Child Development released its first annual report in November 2001. The report includes baseline data on the progress of Prince Edward Island children based on the Understanding the Early Years study. The study shows that out of a possible score of 10, PEI children scored the following: physical health and well-being, 9.0; social knowledge and competence, 8.5; emotional health and maturity, 8.1; language and cognitive development, 8.3; and communication skills and general knowledge, 8.4. Improvements were recommended in several areas such as breastfeeding rates, and rates of exposure by children to second-hand smoke.

Premier Pat Binns accepts PEI's first annual report on children from David Harper, Chair of the Premier's Council On Healthy Child Development.

Access to Services

Several strategies were implemented during the year to increase access to new services and existing services by improving the way they are organized, the way people are referred to them, and the way people work together to deliver services.

ESTABLISHMENT OF NEW MRI AND CANCER TREATMENT SERVICES

The major planning phase to establish Magnetic Resonance Imaging (MRI) and Linear Accelerator services at the Queen Elizabeth Hospital was completed in 2001-2002. The new services will provide Islanders with increased access to curative cancer treatment and high standards of medical diagnosis, while reducing referrals out of province for MRI scans and cancer treatment by 90 percent.

- Functional plans were developed to outline how the services will be delivered and what the requirements will be.
- Much of the design work was finalized for the new 15,000 square-foot addition to the Queen Elizabeth Hospital.
- Equipment tenders were issued in Fall 2001, and contracts awarded in March 2002.
- Preliminary cost estimates were received for $3.8 million for the linear accelerator, $2.6 million for the MRI unit, and $4.5 million for construction.
- Annual operating costs are expected to be approximately $2.5 million, most of which will go to fund more than 20 new full-time equivalent positions.
- Construction will begin later in 2002. The new and enhanced services are expected to be operational by mid-2003.

Liz Dobbin, PEI Cancer Treatment Centre manager advises Premier Binns and Minister Ballem on equipment and human resource needs at a media briefing on progress to establish MRI and enhanced cancer treatment services.

CONSTRUCTION OF THE NEW PRINCE COUNTY HOSPITAL

The final major phase of planning for the new Prince County Hospital was completed in 2001-2002, and by the end of the fiscal year, construction of the new facility was well underway.

- In June, Government announced that the new facility would be built by East Prince Partnerships Limited (EPPL) of Summerside at a cost of $38,150,000.

Mike Schurman, president of East Prince Partnerships Limited (EPPL) speaks at the news conference to announce that EPPL was selected to build the new Prince County Hospital. Looking on are Premier Binns, Katherine Kelly, Board Chair; and Kay Lewis, Senior Planning Officer.

- In March, almost 45 percent of construction was complete. Of the 125 people working on the site at peak periods, as many as 100 were local trades people.
- The major focus of the planning team during the year was the evaluation and ordering of equipment and furnishings. In October, ten requests for proposals were issued for major equipment such as diagnostic, sterilizing, and cardiac monitoring equipment.
- The Prince County Hospital raised an outstanding $12.5 million during the year for equipment.
- Planning continued to determine how new and existing programs and services will be delivered in the new facility using new technology and processes. Transition workshops on change management were held for staff. Committees were established to coordinate and oversee the move to the new hospital.

Artist's rendering of the new Prince County Hospital located off Granville Street in Summerside

ESTABLISHMENT OF NEW LONG TERM CARE BEDS

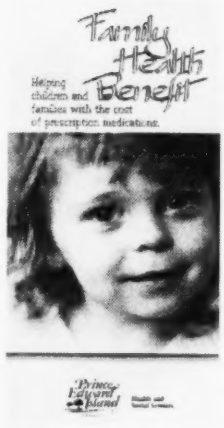
Following the March 2001 announcement by the Salvation Army that they would no longer continue to operate the Sunset Lodge, Government established a transition team to support the transfer of these long term care residents to other facilities.

- In June, Government approved the establishment of 57 new nursing home beds, including 32 at Atlantic Baptist Home, 10 at the Garden Home, 10 at Beach Grove Home, and 5 at the Prince Edward Home.

- With the excellent cooperation of residents, families and staff of Sunset Lodge, and the members of the Private Nursing Home Association, all residents were moved to new facilities by February 2002.

INCREASED DRUG COST ASSISTANCE TO LOWER INCOME FAMILIES

Effective May 1, 2001, enhancements were made to the Family Health Benefit program which assists lower income families with children with the cost of prescription drugs.



- Eligibility for the program was expanded by increasing the income ceiling of $20,000 to $22,000 for a family with one child under 18, and an additional $2000 for each additional child.

- The co-pay was reduced by eliminating the requirement for families to pay any of the drug cost. They now pay only the pharmacy dispensing fee which is usually $5 to $8.

- Changes were also made to simplify the application process by making information and forms available at pharmacies, physician offices and health facilities.

PRIMARY HEALTH CARE REDESIGN

A major Primary Health Care Redesign was initiated to improve access to primary health services which help people to prevent and manage illness. The redesign is also intended to ensure sustainability and quality of work life, and to support a greater focus on prevention and promotion.

The redesign includes five components:

- Family Health Centres where physicians, nurses and other health professionals work collaboratively on multi-disciplinary teams
- Provincial healthy living and chronic disease management strategy
- Integrated palliative care strategy
- Drug utilization program
- Videoconferencing application

A major funding proposal was developed during the year to further implement the initiative with assistance from Health Canada funding for primary care initiatives.

IMPROVED ACCESS TO MENTAL HEALTH SERVICES

Major work was undertaken during the year to develop a best practice model for mental health service delivery that would include prevention, early intervention and treatment services. The new model is intended to address changing trends and increasing demand for services, and gaps in service delivery.

The model proposes four initiatives to balance and strengthen coordination between hospital and community-based mental health services:

- Provincial mental health crisis response system
- Clear designation of provincial and regional services and roles
- Increased client and family participation, education and support
- Increased integration with related supports and services

The proposed new model will serve as the basis for funding and policy direction to meet increasing mental health needs throughout the province.

INTRODUCTION OF NEW DISABILITY SUPPORT PROGRAM

A major new Provincial Disability Support (DSP) Program was introduced to assist persons who have a physical or intellectual disability to overcome barriers, achieve financial independence and a satisfactory quality of life.

This is the first program in Canada to remove disability supports from income support programs, thereby enabling people to work and earn income, and still qualify for the disability supports they need.

The new DSP program focuses on the person rather than the program. Disability-specific supports are provided based on the assessed needs of the individual and/or family as a result of the disability. Approximately 700 Islanders joined the program during its first months of operation in 2002-2003.

The new provincial Disability Support Program brings client, family and staff together to identify goals and resources to assist persons with a disability to become as independent as possible.

A formal evaluation of the program will be undertaken once it is established further.

HOME AND PALLIATIVE CARE

Planning to enhance home and palliative care continued during the year to enable more people to be cared for at home with the appropriate supports.

A major palliative home care pilot project was completed in the Southern Kings Health and East Prince Health Regions, and several initiatives were undertaken to implement the project recommendations. Training was provided for professional and non-professional care providers, a provincial palliative care coordinator was hired, and new investments were made to expand home care services. The project showed that home care is the preferred and most appropriate end-of-life care for patients and families.

Human Resources

EXPANDED NURSING EDUCATION OPPORTUNITIES

In June 2001, government announced the creation of 14 new seats at the UPEI School of Nursing to meet increasing demand for educated and skilled nurses. On full implementation, this will result in an additional 56 spaces in the four-year program, bringing the total number of seats to 59, an increase of 31 percent. New funding of $330,000 per year will be used to provide more courses, faculty and instructors, lab facilities and library resources.

HEALTH HUMAN RESOURCE PLANNING

A major study was released in December 2001 to assist the PEI health sector to plan for and meet current and future human resource needs. The Health Human Resource Supply and Demand Analysis was coordinated by a provincial advisory committee of representatives from the public and private health sectors, the education sector, professional associations and the federal government.

The study includes a comprehensive profile of 4,482 health and social services employees in the public and private sectors, and identifies demand, supply, and predicted surpluses and shortages in major occupational groups over the next five-year period. It also includes a dynamic human resource planning model to support collaborative planning on an ongoing basis among educators, employers and professional associations.

A dedicated Health Human Resource Planner and a Health Human Resource Recruiter were hired during the year to assist in meeting human resource planning and recruitment needs.

Health and Social Services Minister Jamie Ballem reviews Prince Edward Island's first Health Human Resources Supply and Demand Analysis with Anne Marie Atkinson of DMR Consulting.

RECRUITMENT AND RETENTION

Implementation of the provincial $6 million nursing recruitment and retention strategy continued. Efforts to recruit new nurses to the province continued to be successful, as well as summer employment and sponsorship programs to encourage young Islanders to consider a career in nursing and to practice in Prince Edward Island.

Implementation of the provincial $4.2 million Enhanced Physician Recruitment Plan to recruit new doctors and support existing physicians continued. Results during this past fiscal year were: 54 locums through the Locum Support Program; 29 students received assistance through the Medical Education Program; 10 Return in Service grants; 8 moving expense grants; 1 application for Student Loan Assistance Program; and 2 applications for the Medical Trainee Program. There were 11 more full-time physicians practicing in the province at fiscal year end, than the year before.

Information Technology

Several milestones were achieved during 2001-2002 to implement the provincial Island Health Information Technology Strategy, which guides the use of information and technology to enhance health status, improve service delivery and provide information for planning, evaluation and research.

PHARMACEUTICAL INFORMATICS PROJECT (PhIP)

During 2001-2002, a requirements analysis, detailed design and proof of concept were developed for the Pharmaceutical Informatics Project (PhIP). The project links pharmacies, physician offices and emergency rooms, and provide pharmacists and physicians with access to comprehensive prescription profiles to improve diagnostic, prescribing and dispensing decision making.

RADIOLOGY INFORMATION SYSTEM

A new Radiology Information System (RIS) was implemented in all regions this year. This single provincial radiology system maintains comprehensive patient files that can be accessed at any acute care site within PEI.

HEALTH INFOSTRUCTURE ATLANTIC

The Department continues to be an active member of Health Infostructure Atlantic, a group established by the four Atlantic Health Ministers to share health information technology initiatives and identify areas for collaboration and use of best practice. This group was active in 2001-2002 in the collaborative implementation of technology projects across the Atlantic region in such areas as case management, client registry and picture archival and retrieval systems(PACS).

PICTURE ARCHIVAL AND RETRIEVAL SYSTEM (PACS)

The PACS project will enable the creation and transmission of digital radiographic images between hospitals in and out of the province. A Health Infostructure Atlantic initiative, this teleradiology component facilitates remote consultations and better utilization of radiology professionals. During 2001-2002, the development of the Atlantic requirements were completed, and a Request for Proposal for the Atlantic region was issued. The project will move into the implementation phase within PEI in 2002.

INTEGRATED SERVICES MANAGEMENT

The Integrated Services Management (ISM) project is a combination of two information systems, Case Management and Common Client Registry. The principal goal of ISM is to enhance community-based service outcomes through timely, accurate, complete and secure information. In 2001/2002, the requirements phase was completed, and the project moved into the development phase.

CHILDREN'S DENTAL SYSTEM

New information will improve the delivery of the children's dental care program by taking the program from batch technology to an on-line application. This year, the requirement analysis for this project was completed and the implementation phase was initiated.

MATERNAL AND CHILD HEALTH SYSTEM

During the 2001-2002 year, a requirements analysis and detailed design for a new Maternal and Child Health System (MCHS) system were completed. This application will include information on both mother and child from the mother's first point of contact with the health system until the child reaches the age of 18. It will support several areas of service delivery such as public health nursing, nutrition services and reproductive care.

ISLAND HEALTH INFORMATION SYSTEM (IHIS) WIDE AREA NETWORK UPGRADE

IHIS is a province-wide, fully integrated information resource which connects and supports health and social services delivery at over 50 sites. This fiscal year, the Department completed a review of the wide area network for the purpose of ensuring its ability to support future applications. Following this, process was initiated to perform major upgrades through a phased approach. These upgrades will continue in the upcoming fiscal year.

ADMISSION/DISCHARGE/TRANSFER (ADT) PROJECT

A functional plan was developed to support the replacement of the Admissions/Discharge/Transfer (ADT) system and clinical scheduling systems in acute care hospitals. The functional requirements document developed this year will serve as the basis for a Request for Proposal for the new and enhanced systems.

COMMON CLIENT REGISTRY

The Common Client Registry (CCR) is the main client demographic database for the provincial health and social services system. The main repository for all health clients, it stores core demographic attributes such as name, address, date of birth, eligibilities, encounters and ID. The final development phase for this application was completed in 2001-2002. The new Common Client Registry will become fully operational early in the upcoming fiscal year.

HEALTH FINANCIAL SYSTEM (HFS) UPGRADE

During the 2001-2002 fiscal year, planning was completed for a migration to a new version of the Oracle financial application, which is now used by all regional authorities. The upgrade from R10.7 to R11i is a significant one. The project has now moved into the implementation phase with the development of the project plan and the creation of the project team.

PROJECT MANAGEMENT METHODOLOGY

During 2001-2002, a new project management methodology was developed and implemented within the Health Informatics Division to better manage projects and resources.

Partnerships

Recognizing that good health and well-being are determined by many factors outside the scope of the health system, several strategic initiatives were taken during the year by the Department of Health and Social Services to build and support effective alliances which impact on the determinants of health and well-being.

- The Department of Health and Social Services led the development of a Provincial Healthy Living Strategy to address PEI's high rates of chronic disease. Partners in the provincial strategy include community alliances, other government departments, health regions and health professionals.

- Specific strategies to prevent and reduce the risk factors for chronic disease (high smoking rates, poor eating practices and low physical activity rates) are being led by provincial alliances of individuals, community and non-government organizations, professional associations and government departments. These include the PEI Tobacco Reduction Alliance (PETRA) and the PEI Active Living Alliance. A PEI Healthy Eating Alliance is now being established following several initiatives undertaken by the Department to determine interest and direction for an alliance to promote healthy eating, particularly among children and youth. The Departments of Health and Social Services, Education and other departments provide resources for strategic planning and the operation of the alliances, along with other partners.

- The Department of Health and Social Services and the Department of Education are lead partners within the Provincial Healthy Child Development Strategy. The aim of the strategy is to monitor the health of Island children and promote healthy child development, which has a tremendous impact on lifelong health and well-being.

- The Department of Health and Social Services and the Department of Education are now leading the development of an integrated Provincial Autism Strategy to increase access to early intervention and other services for children with autism and families, and to ensure smooth transitions throughout the continuum of these services.

- The Department continues to work with its regional and federal partners on several public health initiatives such as monitoring for West Nile Virus and Raccoon Rabies, and contingency planning for potential public health issues such as a pandemic influenza.

- The Department of Health and Social Services is a lead partner within the PEI Health Research Program, which partners with national agencies and local organizations to solicit, evaluate and fund research proposals to address health and health services.

RESULTS ACHIEVED

The Strategic Plan for the Health and Social Services System outlines five goals to improve the health of Islanders and the sustainability of the system:

1. Improve the health status of Islanders
2. Increase acceptance of responsibility for our own health
3. Improve the sustainability of the system
4. Increase public confidence in the system
5. Improve workplace wellness and staff morale
6. Maintain other results at current levels

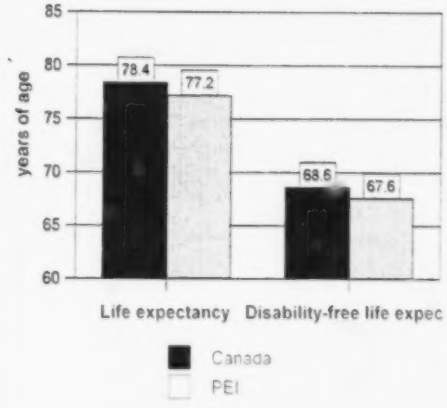
As part of the planning process, indicators were identified to assess progress toward achievement of each goal. Reporting on those indicators is included in the following section of this report.

The most recent data available is reported, which in most cases is 1999 data, and in some cases 2001 data. Where possible, PEI data was compared to national averages to indicate how we compare to other jurisdictions.

Goal #1 ~ Improve the health status of Islanders

LIFE EXPECTANCY AND DISABILITY-FREE LIFE EXPECTANCY

Life expectancy & disability-free life expectancy, at birth, 1996, Canada and PEI



Source: Statistics Canada, Vital Statistics, Death Database and Demography Division; ISQ
Exclusions: non-residents of Canada

Life expectancy is reported as the number of years a person would be expected to live on average, starting from birth, and based on the death rates for a calendar year.

Disability-free life expectancy complements conventional life expectancy measures and reflects the fact that not all years of a person's life are typically lived in perfect health. Chronic disease, frailty, and disability are more common at older ages, which means that a population with a higher life expectancy may not be a healthier one. Disability-free life expectancy is reported as the number of years a person would be expected to live, on average, free of moderate or severe disability, starting from birth. *Moderate or severe disability* refers to experiencing at least one activity limitation.

Summary: In 1996, the life expectancy of Islanders was similar to that of Canada. PEI women lived longer on average than men by 6.9 years. In 1999, the life-expectancy rate for PEI had increased from 77.2 to 78.4 years.

The 1996 disability-free life expectancy for PEI was 67.6 years as compared to the overall life expectancy of 77.2. Thus in 1996, Islanders, on average, lived 9.6 years with a moderate or severe disability. Women's disability free life expectancy was 4.7 years higher than men's.

LOW BIRTH WEIGHT

Low birth weight is an indicator of the general health of newborns. It is a key factor affecting infant survival and risk of disability and diseases such as cerebral palsy, visual problems, learning disabilities and respiratory problems. Appropriate medical care and a healthy lifestyle for the mother can improve the chances that the baby will have a healthy birth weight. Low birth weight is reported as the percentage of live births with a birth weight between 500 and 2500 grams for a given year.

Summary: PEI continues to have a relatively low rate of low birth weight babies. In 1999, the PEI rate was 5.2%, similar to the national average of 5.5%. This is considered good compared to the standard of 5.0% for most developed countries. (Source: Statistics Canada, Vital Statistics, Births database; ISQ)

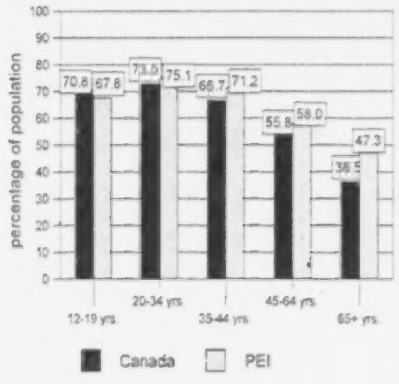
SELF-REPORTED HEALTH

Self-reported health is a general indicator of overall health status and reflects how healthy individuals feel they are. It includes what other measures like life expectancy may miss such as the impact of disease, coping skills, psychological attitude and social well-being on health.

Self-reported health is reported as the percent of the population who reported their health as "very good" or "excellent" on the Canadian Community Health Survey in 2000/01.

Summary: In 2000/01, 64.4% of Islanders reported their health as very good or excellent, similar to the Canadian average of 61.4%. However, older Islanders like older Canadians were less likely to report very good or excellent health.

Percent reporting "excellent" or "very good" health, age 12+, Canada and PEI, 2000/01, by age group



Source: Canadian Community Health Survey – Cycle 1.1 – 2000/01
Exclusions: non-residents of Canada; persons living on military bases or First Nation Reserves and Crown lands; residents of institutions; full-time members of the Canadian Armed Forces; residents of certain remote regions.

OCCURRENCE OF CHRONIC DISEASES

Chronic disease is the major cause of death, potential years of life lost, hospitalization and reduction in quality of life in PEI. Reporting the prevalence or incidence of chronic diseases gives an indication of how widespread a disease is, who is being affected (for example age and sex groupings), and whether the rates are increasing or decreasing over time. This information also helps people in the health care system to better understand the social impact and economic burden of these diseases.

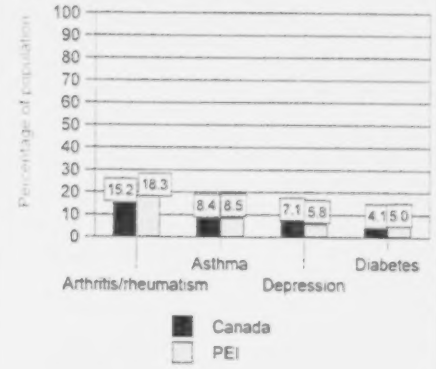
The chronic diseases reported here are:

- Prevalence of arthritis/rheumatism, asthma, depression and diabetes
- Incidence of lung, colorectal, prostate and breast cancer.

Prevalence of arthritis/rheumatism, asthma, depression and diabetes

The prevalence of a disease refers to the total number of cases in a year. The prevalence is reported as the percent of the population aged 12 and over who reported being diagnosed by a health professional as having a particular disease on the Canadian Community Health Survey in 2000/01. It is important to note that these rates are based on self-reported data and may not accurately represent the prevalence of these diseases. For arthritis/rheumatism, this includes both rheumatoid arthritis and osteoarthritis, but excludes fibromyalgia. Depression refers to those who have a probable risk of depression based on their responses to a series of survey questions.

Prevalence of Chronic Diseases, age 12+, PEI and Canada, 2000/01



Source: Canadian Community Health Survey – Cycle 1.1 – 2000/01
Exclusions: non-residents of Canada; persons living on military bases or First Nation Reserves and Crown lands; residents of institutions; full-time members of the Canadian Armed Forces; residents of certain remote regions.

Summary: In 2000/01, the prevalence of arthritis/rheumatism in PEI was 18.4%, which was above the national average of 15.2%. The rate for Island women was above the rate for men.

In 2000/01, the PEI prevalence of asthma was 8.5%, similar to the Canadian average of 8.4%. The rate for Island females was above the rate for males.

In 2000/01, 5.8% of Islanders appeared to be at risk of having depression, which is below the Canadian average of 7.1%. Island women were at greater risk of having depression than men.

Prevalence of diabetes (age-standardized)		
	Canada*	**PEI**
1997/98	4.3%	3.9%
1998/99	4.8%	4.5%
1999/00	5.1%	4.6%

*Data for Canada excludes New Brunswick, Newfoundland, Nunavut and NWT

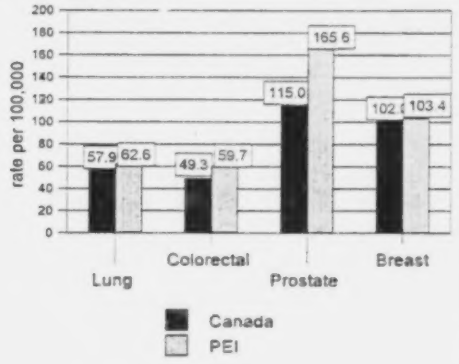
In 2000/01, 5.0% of Islanders age 12 years and over reported that they had been diagnosed with diabetes. This is similar to the Canadian average of 4.1%. Island men have a higher prevalence rate of diabetes than do women.

An additional source of diabetes information comes from the National Diabetes Surveillance System, a relatively new system with only three years of data which is to be considered provisional. Over the three year period reported, the prevalence of diabetes in PEI increased by 18% from 3.9% of the population to 4.6%. PEI rates have been similar to the Canadian average. In terms of age and sex differences, the 1998/99 PEI rates show a steady increase in the prevalence of diabetes from age 20 (0.8%) to age 80 (15.5%) with male rates being slightly above female rates.

INCIDENCE OF LUNG, COLORECTAL, PROSTATE AND BREAST CANCER

The incidence rate of these cancers is reported as the number of <u>new</u> cases in a given year per 100,000 population.

Cancer incidence rates (age-standardized), Canada and PEI, 1997



Source: Statistics Canada, Canadian Cancer Registry, and Demography Division; ISQ
Exclusions: non-residents of Canada

Summary: In 1997, PEI had an incidence of lung cancer which was slightly above the national average. The rate for Island males was twice the rate for females. While male rates are higher, data over time shows that female rates are catching up. Over the previous 20 years, the rates for both men and women had increased to the point of doubling for men and tripling for women.

In 1997, the overall PEI incidence of colorectal cancer was above the national average.

The incidence of prostate cancer for Island men was high at 165.6 per 100,000 men and was above the Canadian average. Over the previous 20 years, the PEI and Canadian rates more than doubled.

In 1997, PEI had an incidence of breast cancer that was almost the same as the Canadian average. Over the previous 20 years, the incidence rates for both PEI and Canada had increased by about 20 women per 100,000.

INCIDENCE OF VACCINE PREVENTABLE DISEASES

A number of diseases can be controlled by adequate immunization programs. Vaccines for these diseases are administered under provincial and territorial immunization programs across Canada and each province and territory is required to report the occurrence of these diseases. In this way, information can be gathered on the effectiveness of each immunization program and monitored over the longer term. The incidence rate of the six vaccine-preventible diseases reported here refers to the number of new cases in a given year per 100,000 population.

<u>Invasive meningococcal disease - under age 20:</u> A new generation of very effective vaccines are now available to protect against this disease. They can be given to infants as young as two months of age. The National Advisory Committee on Immunization (NACI) recommends three doses of this vaccine. PEI and most other provinces does not routinely provide this immunization but does provide it for individuals who are at increased risk. Since 1993, PEI had only two reported cases of invasive meningococcal disease, resulting in a rate of 2.5 in 1993 and 2.6 in 1998. (Source: Notifiable Disease Reporting and Enhanced Surveillance System)

<u>Invasive haemophilus influenzae b (Hib) disease - children under 5 years</u>: In Canada, Hib disease was the most common cause of bacterial meningitis and a leading cause of other serious invasive infections in children under 5 prior to the introduction of a four-dose schedule of Hib vaccines which began in PEI in 1992. Since then, PEI has had only one case in 1994 which translates to 10.6 cases per 100,000 children under age 5. (Source: Notifiable Disease Reporting and Enhanced Surveillance System)

Measles: The elimination of measles is a national and provincial goal. PEI has had no cases of measles since it began giving the suggested two doses of vaccine in 1997, and only 9 cases over the 20 year period from 1980 to 2000. (Source: Notifiable Disease Reporting and Enhanced Surveillance System)

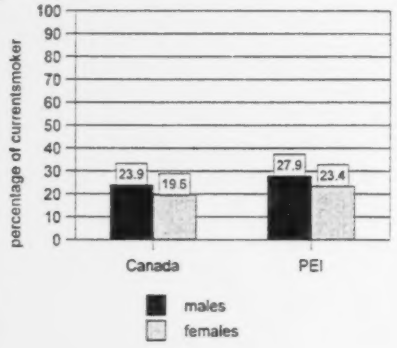
Hepatitis: The two main forms of vaccine preventable hepatitis (hepatitis A and B) are infections of the liver caused by direct exposure to the blood or body fluids of infected persons. The PEI rates for all groups of hepatitis were well below the Canadian average (Source: Centre for Infectious Disease Prevention and Control, Health Canada)

Pertussis: Pertussis, or whooping cough, caused by a bacterium that is easily transmitted from one person to another, can be prevented by a vaccine. The ten year (1990-1999) average incidence rate of pertussis in PEI was 19.0 per 100,000 which was below the Canadian ten year average of 22.8. (Source: Discharge Abstract Database, CIHI)

SMOKING RATES

Tobacco use is the leading cause of preventable illness and death in Canada. Health Canada estimates that smoking is responsible for more than 45,000 deaths per year. Of particular concern is the rate of young people smoking, for example age 15 to 25, because of the addictive nature of nicotine. It is estimated that approximately 8 out of every 10 people who try smoking become habitual smokers. This indicator reports the percentage of the population over age 15 who reported they were current smokers on the Canadian Tobacco Use Monitoring Survey, 2001. It is important to note that these rates are based on self-reported data and may not accurately represent the real prevalence of smoking. Survey respondents can provide socially desirable responses to survey questions and in doing so, may under report their smoking behaviour.

Percentage of self-reported current smokers, age 15+, by sex, Canada and PEI, 2001



Source: Canadian Tobacco Use Monitoring Survey 2001

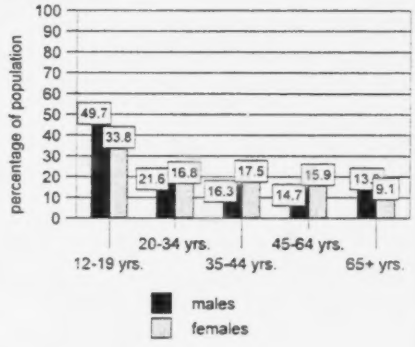
Summary: In 2001, 25.6% of Islanders reported being current smokers, which is above the national average of 21.7%. This PEI rate is down slightly from the 26.0% rate reported in 2000. For both PEI and Canada, young adults age 20 to 24 continue to have the highest smoking rate of any age group, at 34.8% for PEI and 32.1% for Canada. For both PEI and Canada, more males than females reported that they were current smokers. For PEI, the rates for both males and females in the age groups 15 to 24 and 25+ are down slightly from the 2000 rates, except for females in the 25+ group which is up slightly from 21% in 2000.

PHYSICAL ACTIVITY RATES

Maintaining physical activity is associated with a range of health benefits such as heart health and positive mental health. This indicator is reported as the percentage of the population over 12 who were rated as "active" on the physical activity index on the Canadian Community Health Survey, 2000/01. It is important to note that these rates are based on self-reported data and may not accurately represent the real rates of activity. Survey respondents can provide socially desirable responses to survey questions and in doing so, may over report their activity levels.

Summary: In 2000/01, only 19.6% of Islanders over age 12 self-reported a physical activity index of "active" which was similar to the Canadian rate of 21.0%. Island males were more active overall particularly in the 12 to19 age group. Being physically active declined with age, with the largest decrease between the 12-19 age group and the 20-34 age group.

Percentage of population self-reporting as physically "active", by age group and sex, PEI, 2000/01

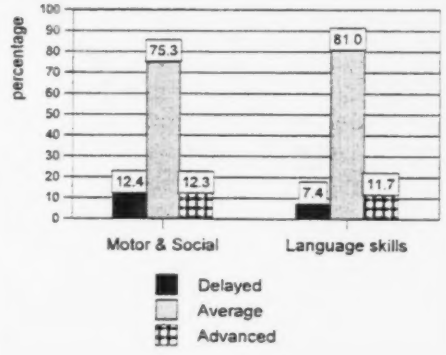


Source: Canadian Community Health survey – Cycle 1.1, 2000/01
Exclusions: persons living on First Nation Reserves and on Crown lands; residents of institutions; full-time members of the Canadian Armed Forces; residents of certain remote regions.
Note: Interpret with caution-coefficient of variation between 16.6% and 33.3%: males 65+

READINESS TO LEARN

These indicators provide information on how "ready" a child is to begin learning at school. The four indicators presented here focus on the physical, emotional, and social well-being of children, as well as their language skills, based on data from the National Longitudinal Survey of Children and Youth. *(Source*: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99)).

Motor and social development, children age 0-3 & PPVT-R score for children age 4-5 PEI, 1998/99



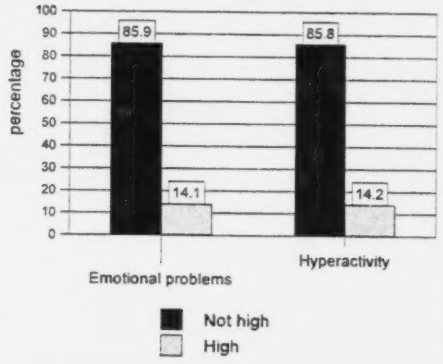
Motor and social development and language skills

The majority of Island children aged 0 to 3 have an average level of motor and social development. Only 12.4% were delayed. The majority of Island children aged 4 to 5 had an average receptive or hearing vocabulary per their score on the Peabody Picture and Vocabulary Test - Revised (PPVT-R). Only 11.7 % were delayed. The results for both of these indicators were very similar to the Canadian average.

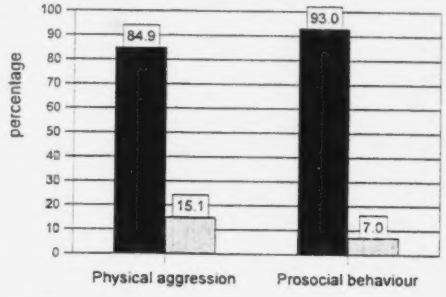
Emotional health

The majority of Island children age 2 to 5 did not exhibit high levels of emotional problems or hyperactivity. These results were very similar to the Canadian average.

Emotional problem/anxiety & hyperactivity/ inattention scores, children age 2-5, PEI , 1998/99



High aggression & Prosocial behaviour scores, children age 2-5, PEI, 1998/99

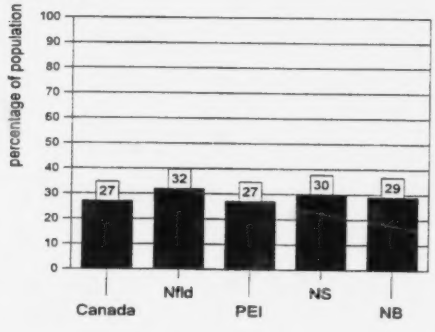


Social knowledge and competence

The majority of Island children age 2 to 5 did not exhibit high levels of physical aggression, and an even higher rate demonstrated positive social behaviour. These results were similar to the Canadian average.

Goal #2 ~ Increase acceptance of responsibility for our own health

Percentage of children age 0-17 regularly exposed to second hand smoke, Canada and PEI, 2000



Source: Health Canada 2000, Canadian Tobacco Use Monitoring Survey (CTUMS), Household Component, February - December, 2000.

CHILDREN EXPOSED TO SECOND HAND SMOKE

Exposure to second hand smoke can have a detrimental effect on children's health by putting them at risk for a number of respiratory conditions. This indicator reports the percentage of children age 0 to 17 who were reported to be regularly exposed to second hand smoke in their homes.

Summary: In 2000, 27% of Island children were reported to be regularly exposed to second hand smoke in their homes. This rate was the same as the Canadian average and below the rates for other Atlantic provinces.

IMMUNIZATION FOR INFLUENZA RATES

Immunization against influenza has been shown to be effective for adults over 65 in preventing the flu. This indicator is reported as the percent of the population 65 years and over, who reported that they had a flu shot within the last year on the Canadian Community Health Survey, 2000/01.

Summary: In 2000/01, just over half of Islanders between 65 to 74 reported being immunized for the flu within the last year, and only 33% reported never having had a flu shot. For those 75 years and over, the rate for having a flu shot within the last year was even higher at 71.8%. The rates for both age groups were similar to the Canadian average. (Source: Canadian Community Health Survey – Cycle 1.1, 2000/01)

MAMMOGRAPHY RATES

Breast cancer continues to be the most common cancer afflicting Canadian women and more than half of all new cases occur among those aged 50 to 69. Over the past several years, provincial and territorial breast cancer screening programs have collaborated in the development of a national database to monitor and evaluate breast cancer, and provincial breast cancer screening programs have grown substantially. The national recommendation is that 70% of women aged 50 to 69 participate in the screening program every two years and this is the same for PEI.

PEI's breast cancer screening program began in February 1998. The goal of the program is to screen 70% of all Island women 50 to 69 years of age every two years. In 2001, this population was 15,455.

PEI Provincial Breast Screening Program Rates and Cancer Detection Rates, 2001	
Annual catchment target	7727
Number of women screened in 2001	5354
Rate of annual catchment	69.2%
Provincial rate of cancers detected	4 per 1,000 screens
Source: Provincial Breast Screening Program	

Summary: In 2001, 69.2% of the annual provincial catchment target was screened, which is very close to the 70% target rate set nationally and provincially. It is important to note that this one year rate does not necessarily reflect the rate of women being screened every two years as some women go for screening every year and are thus counted twice in a two year time frame.

In 2001, there were 19 new breast cancers detected in PEI which represents 4 per 1,000. This is a very good detection rate, according to the national standard which indicates that a detection rate between 3 and 5 should be achieved through a provincial breast screening program.

PAP SCREENING RATES

Over 90% of cervical cancer can be prevented by regular screening with the Pap test. Data shows that since the 1960s, PEI cervical cancer rates have been increasing while the national rates have decreased. It is also reported that most cases of cervical cancer occur in women not regularly screened. Pap screening rates reflect the percentage of women between 20 and 69 in a given population who have participated in Pap screening within a defined period of time.

The PEI Pap Screening Program was established in 2001 to: reduce the incidence of and mortality from cervical cancer among Island women; increase accessibility to service; and to increase the number of women screened.

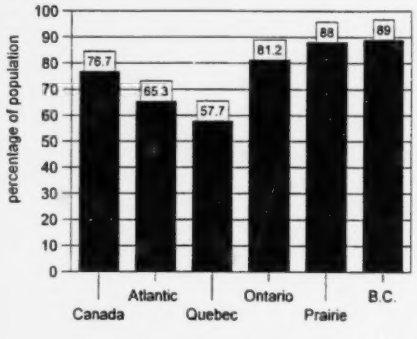
Summary: The PEI Pap Screening Program reported that for 2001, the annual Pap screening rate for Island women aged 20 to 69 was approximately 40% which has been the same since 1995. Over a three year period, approximately 65% of Island women aged 20 to 69 were screened. Pap screening decreases with age. (Source: *PEI Pap Screening Program 2001 Report*, 2002)

Another source of Pap screening rates is the Canadian Community Health Survey (CCHS). These participation rates are based on self-report and tend to be less accurate than the findings from the Pap Screening Program above. Survey respondents can provide socially desirable responses to survey questions and in doing so, may over or under report their activities. However, this CCHS data does allow for a comparison to the Canadian average. In 2000/01, 78.8% of Island respondents indicated that they had a Pap screen within the past 3 years, which is above the Canadian average of 72.7%. The 35 to 44 year age group had the highest rate. In all age groups, the PEI rate was above the Canadian average, particularly for the 45 to 69 year age group. (Source: Canadian Community Health survey – Cycle 1.1, 2000/01)

BREASTFEEDING RATES

Breastfeeding is acknowledged to be an ideal source of nutrition for babies because it contains immunoglobulins and antibodies that fight infection. Breastfed children tend to have less early childhood illness like respiratory infections, asthma, eczema and food allergies.

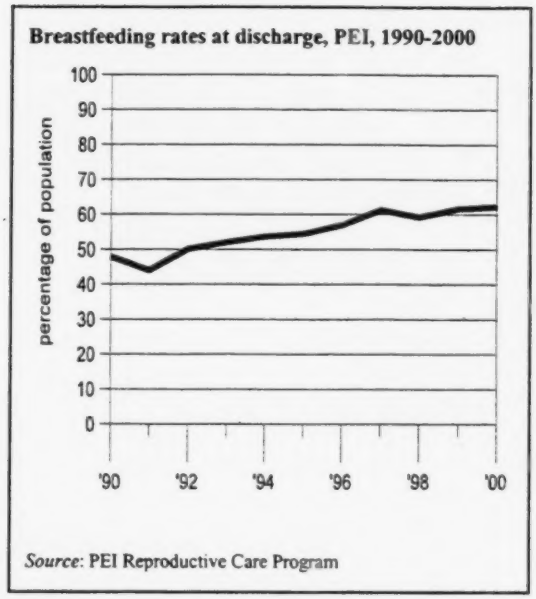
Prevalence of breastfeeding by region/ province, 2000



Source: Health Canada, 2000(a). *Canadian Perinatal Health Report*. Ottawa: Minister of Public Works and Government Services Canada.

The first two sources of information below are based on self-report data and the third is data collected through the PEI Reproductive Care Program. Self-report data tends to be less accurate as survey respondents can provide socially desirable responses to survey questions and in doing so, may over or under report their activities. However, these sources allow for comparisons to the Canadian average.

Summary: The first graph presents data on the percentage of women who delivered and have ever breastfed their babies in 2000 for five regions in Canada. It shows that the Atlantic region had the second lowest breastfeeding rate across Canada at 65.3%. Only Quebec was lower at 57.7%.



Findings from the Canadian Community Health Survey, 2000/01 showed the PEI rate of mothers aged 15 to 49 who ever breastfed or tried to breastfeed a recently-born child was 68.6% which is below the Canadian average of 79.3%.

The second graph presents a time trend of breastfeeding rates at discharge from hospital after birth which has been tracked by the PEI Reproductive Care Program. The trend shows that the PEI rate was above 60% in 2000 and that there had been steady improvement since 1990 .

Goal #3 ~ Improve the sustainability of the system

PEI HEALTH AND SOCIAL SERVICES EXPENDITURES

PEI Health and Social Services System Program expenditures (in current dollars), 99/00 to 01/02

	1999/00	2000/01	2001/02
Health Care expenditures	$237.0 M	$257.3 M	$294.0 M
Social Services expenditures	$73.6 M	$77.0 M	$76.6 M
Total System expenditures	$310.6 M	$334.3 M	$370.6 M

Source: PEI Department of Health and Social Services, Finance and Administration, 2002

Summary: In 2001/2002, total provincial government spending on Health and Social Services was $370.6 million. This represents about 39% of the total PEI government expenditures of $955.8 million. There was a $23.7 million (7.6%) increase in Health and Social Services total system spending from 1999/00 to 2000/01, and $35.7 million (10.7%) from 2000/01 to 2001/02 .

HEALTH AND SOCIAL SERVICES COSTS PER CAPITA

PEI Health and Social Services costs per capita (in current dollars), 1999/00 to 2001/02			
	1999/00	2000/01	2001/02
Health Care cost per capita	$1,722	$1,863	$2,122
Social Services cost per capita	$535	$558	$553
Total System cost per capita	$2,256	$2,421	$2,676
Source: PEI Department of Health and Social Services, Finance and Administration, 2002			

Summary: In 2001/02, the average cost per capita for provincial government spending for Health and Social Services in PEI was $2,676. About three quarters of that cost are related to health care. The total per capita cost increase was $165 (7.3%) from 1999/00 to 2000/01, and $255 (10.5%) from 2000/01 to 2001/02.

HEALTH PROFESSIONALS

Monitoring the number of health professionals in a population is one indicator of how adequately the population is being served. This indicator is reported as the number of health professional per 100,000 population.

Summary: In 2000, PEI had a mixed picture in terms of the number of health professionals. PEI had a rate above the national average for Registered Nurses, Licenced Practical Nurses and Pharmacists. In fact the rate of Licenced Practical Nurses in PEI was twice that of the national average. However, PEI had a rate below the national average for other health professionals, such as physicians, dentists, psychologists, dental hygienists, and optometrists. It is important to note that Islanders go out of province to receive some services. Even though some specialty physician and other services are not available in PEI, Islanders do have access to them in nearby provinces.

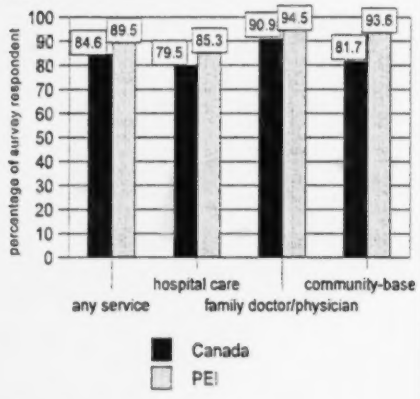
Health professionals, rate per 100,000 population, 2000		
	Canada	**PEI**
Registered Nurses	752	908
Licensed Practical	207	451
General Practitioner/	94	76
Specialist Physician	93	53
Pharmacists	79	86
Dentists	56	43
Physiotherapists	47	34
Psychologists	43	15
Dental Hygienists	48	31
Chiropractors	18	5
Optometrists	11	8
***Source*: CIHI Health Indicators 2002**		

PATIENT SATISFACTION WITH SERVICES

Patient satisfaction with services is one indicator of the quality of services. Patient satisfaction was measured through items on the Canadian Community Health Survey, 2000/01. This indicator reports the percentage of the adult population who rated themselves as either very satisfied or somewhat satisfied with the way the following services were provided: a) any health care services; b) hospital services; c) physician services; and d) community-based services received. Community-based services include home nursing care, home-based counseling or therapy, personal care and community walk-in clinics.

Summary: In 2001, Islanders, like Canadians as a whole, appeared to be satisfied with the health care services they received. 89.5% were very or somewhat satisfied with any of the health care services they received, 85.3% with hospital care, 94.5% with physician services and 93.6% with community-based services.

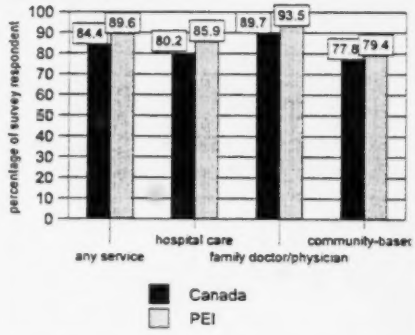
Percentage very satisfied or somewhat satisfied with any health care service, hospital care, physician care, and community based health care, age 15+, PEI and Canada, 2000/01



Source: Canadian Community Health Survey - Cycle 1.1 2000/01
Exclusions: non-residents of Canada; persons living on military bases or First Nation Reserves and Crown lands; residents of institutions; full-time members of the Canadian Armed Forces; residents of certain remote regions.

Goal #4 ~ Increase public confidence in the system

Percentage rating quality of service as excellent of very good for: any health care service, hospital care, physician care, and community based health care, age 15+, PEI and Canada, 2000/01



Source: Canadian Community Health Survey - Cycle 1.1 2000/01
Exclusions: non-residents of Canada; persons living on military bases or First Nation Reserves and Crown lands; residents of institutions; full-time members of the Canadian Armed Forces; residents of certain remote regions.

PUBLIC CONFIDENCE

Public confidence in the Health and Social Services System can be measured by a public rating of the quality of services received. Perceptions of service quality were measured through the Canadian Community Health Survey in 2000/01.

This indicator is reported as the percentage of the population rating any health care service, hospital care, physician services and community-based services as very good or excellent. Community-based services included home nursing care, home-based counseling or therapy, personal care and community walk-in clinics.

Summary: Islanders generally responded positively about the quality of care they received. 89.6% rated the quality of any health care service as very good or excellent, 85.9% for hospital care, 93.5% for physician services and 79.4% for community based services. In all four of these areas the PEI rate was above the Canadian average.

Goal #5 ~ Improve workplace wellness and staff morale

WORKPLACE WELLNESS AND STAFF MORALE

The table below presents a profile of the number of permanent employees working in the Health and Social Services System over the last two years.

Permanent Employees in the Health and Social Services System April 2000 to March 2002				
	Number as of April 1, 2000	Number as of March 31, 2001	Number as of April 1, 2001	Number as of March 31, 2002
Department	141	145	145	159
Health Regions	3,411	3,698	3,698	3,952
Total	3,552	3,843	3,843	4,111
Total rate of increase	8.2%		7.0%	

Summary: Employees of the Health Regions who deliver the programs and services across the Island account for the majority of the workforce, while employees of the Department of Health and Social Services make up less than 4%. Comparing the fiscal year end 2000-2001 with the fiscal year end 2001-2002, there was an increase in the number of permanent employees across the system of 7%.

LEAVE OF ABSENCE UTILIZATION

There are several ways to measure workplace wellness and staff morale. The number and length of leaves of absence taken by staff are an indication of staff physical and mental health. The bulk of leaves of absence in the Health and Social Services system are sick leaves. This indicator is reported as a) the percentage of total work days for all full-time equivalent staff that were taken as sick days b) the cost of sick days (cost of lost productivity) and; c) the average number of sick days per year per full time equivalent employee.

Sick leave utilization in the Health and Social Services System, 1999/00 to 2001/02		
	2000/01	2001/02
	Health & Social Services System	Health & Social Services System
Total hours	6,994,161	7,095,510
Total sick hours	256,495	256,854
Percentage of work days that were taken as sick days	3.7%	3.6%
Cost of sick days	$4.6M	$5.0M
Average number of sick days used per year per FTE*	9.6	9.4
*FTE is "full-time equivalent" and refers to full-time hours which is 1,950 hrs. per year.		

Summary: The percentage of sick days taken by staff of the Health and social Services System remained stable over the two-year period. The average number of sick days per year per staff member also remained stable.

WORKERS' COMPENSATION BOARD CLAIMS IN THE HEALTH AND SOCIAL SERVICES SYSTEM

This indicator reports: a) the number of new claims for workers' compensation and; b) the number of workers' compensation days used.

Worker's Compensation Board claims by Health and Social Services System employees 1999 to 2001			
	1999	2000	2001
Number of new claims	243	252	208
Number of days claimed	12,147	11,702	6,108

Summary: The number of new claims made in 2001 was down somewhat from the previous two years. More significant was the decrease in the number of days used in 2001 which were almost half of that in the previous two years.

LONG TERM DISABILITY CLAIMS

This indicator refers to the number of approved long term disability claims made per year by employees of the Health Regions.

Long term disability claims, Health Regions only*, 1998 to 2000			
	1998	1999	2000
Total claims	20	16	21
*LTD data is available for the whole Civil Service, but not for the individual departments. Therefore, only the employees of the Health Regions, and not the employees of the Department of Health and Social Services, are included in the numbers above.			

Summary: A very small number of employees in the Health Regions took long term disability leaves, and these varied slightly over the reported three year period.

PHYSICIAN RECRUITMENT SUCCESS

All provinces are experiencing physician shortages, both in family medicine and speciality areas. Vacancies in the physician complement, regardless of whether they are in family medicine or one of the specialities, have an impact on services to the general public. Recruitment is an on-going process and there will always be vacancies within the physician complement, whether they are caused by retirement or physicians choosing to leave the system.

To date, the PEI Physician Recruitment Strategy has had many successes. Recruitment success reflects the number of positions filled in a given year and serves as a useful indicator to monitor the success of recruitment efforts. In PEI, the Physician Resource Planning Committee established a "physician complement", which is the total number of allowable positions for physicians in PEI. This indicator reports on the number of physician complement positions, in the family practice and specialist categories, compared to the number of filled positions for a given time period.

Physician complement and filled positions, PEI				
	As of March 2001		As of March 2002	
	Compliment	Filled*	Complement	Filled*
Family Practice	75	70.5	75	72.8
Specialists	93.9	76.8	96.1	85.5
TOTALS	**168.9**	**147.3**	**171.1**	**158.3**
Filled positions reflect a full-time equivalent based on both permanent & locum positions.				

Summary: The number of physician positions filled increased from 147.3 in 2001 to 158.3 in 2002. The percentage has also increased with 87.2% of the possible physician positions being filled in 2001 to 92.5% filled in 2002. While PEI remains just below complement in some physician practice areas there was an increase in Family Practice, Obstetrics/ Gynecology, Oncology, Psychiatry, Physical Medicine, Surgery and Radiology.

REGISTERED NURSE RECRUITMENT SUCCESS

Registered Nurses comprise the largest group of health care providers. Maintaining an adequate supply of nurses involves attracting new nurses and retaining existing nurses. The PEI Nursing Recruitment and Retention Strategy includes several initiatives to: a) attract nurses by creating new positions and sponsoring Bachelors of Nursing students and; b) retain nurses through initiatives such as cost assistance for RN's who take refresher courses. This indicator reports on these three initiatives, as well as the number of nurses recruited to work in PEI.

PEI Nursing Recruitment and Retention Strategy		
	2000/01	**2001/02**
Number of new RN positions established	27	15
Number of Student Sponsorships (for 3rd and 4th year) *	24	35
Number of RNs recruited to PEI	27	18
Number of RNs receiving Refresher Program Cost Assistance	2	4

*Students who receive this sponsorship subsequently spend one year working in the PEI health system.

Summary: Over a two year period from 2000/01 the Nursing Recruitment and Retention Strategy initiatives resulted in the establishment of 42 new nursing positions, sponsorship of 59 nursing students and recruitment of 45 new nurses to work in the PEI health system. The number of student sponsorships increased considerably in 2001/02. This is significant because sponsored students are required to work one year in the PEI health system upon graduation.

ATTRITION RATES

Attrition refers to the number of employees who leave their position for one reason or another. This indicator reports on: a) the rate of those who have left the system, by their reason for leaving; and b) the rate who relocated within the Health and Social Services System by type of relocation.

ATTRITION FROM THE HEALTH AND SOCIAL SERVICES SYSTEM

The number of permanent employees leaving employment in the Health and Social Services system has decreased over the last two years. In 2000/01, 137 out of 3,843 (3.6%) left and in 2001/02, 121 out of 4,111 (2.9.1%) left.

Rate of permanent employees who left the Health and Social Services System by reason for leaving, April 2000/01 and March 2001/02			
Reason for Leaving		April 2000/01	March 2001/02
Resignation		34%	45%
Retirement	Regular Retirement	34%	36%
	Early Retirement	8%	3%
	Voluntary Retirement 2002	not applicable	3%
Health reasons, family reasons or death		16%	8%
Failure to return from leave, terminated from LTD/WCB, layoff, or unsatisfactory performance		8%	5%

Summary: For both 2000/01 and 2001/02, resignations and retirements accounted for over 80% of the attrition from the system. The resignation rate was considerably higher in 2001/02, whereas personal reasons were somewhat higher in 2000/01.

RELOCATION WITHIN THE HEALTH AND SOCIAL SERVICES SYSTEM

Relatively few employees relocated within the Health and Social Services system over the last two years. In 2000/01, 45 out of 3843 (1.2%) relocated, and 44 out of 4111 (1.1%) relocated in 2001/02.

Rate of permanent employees who relocated within the Health and Social Services System by type of relocation, April 2000/01 and March 2001/02		
	April 2000/01	March 2001/02
Resigned and took another position	73%	68%
Transferred to another position	27%	32%

Summary: For both 2000/01 and 2001/02, more than twice as many employees resigned from a position (to take another one in the system) than were transferred within the system.

EMPLOYEE ASSISTANCE PROGRAM UTILIZATION

The Employee Assistance Program (EAP) supports the health of employees and a productive and satisfied workforce. Through the program, confidential counseling is offered to employees, as well as group sessions focused on wellness in the worksite. EAP confidential counseling utilization rates give an indication of the number of employees with health needs and the willingness of employees to seek the supports they need to ensure their own wellness. This indicator reports on confidential counseling data and is reported as: a) the number of employees in the Health Regions who use EAP services by year and; b) the breakdown of those who use EAP by age group and years of service. EAP data is available for the whole Civil Service, but not for the individual departments of government. Therefore, only the employees of the Health Regions, and not the employees of the Department, are included in the numbers below.

Employee Assistance Program utilization rates, Health Regions, 2000/01 and 2001/02			
Age & Years of Service Breakdown		2000/01	2001/02
Age groups	36-45 years old	42.4%	38.2%
	46-55 years old	23.6%	21.5%
Years of service	6-10 years	25.0%	22.5%
	11-19 years	41.3%	38.1%
	20+ years	12.3%	12.0%

Summary: A relatively large number of Health Region employees used EAP services in the last two years. In 2000/01, 492 out of 3,698 (13.3%) used EAP and 614 out of 3,952 (15.5%) used the services in 2001/02. Approximately 20% more Health Region employees used the services of the EAP in 2001/02 than in the previous year.

For both years, the top three presenting problems were marital/partner issues, job conflict and anxiety. Each year, over one quarter of those using EAP services indicated that their presenting problem impacted the quality or quantity of their work. Close to 20% indicated that their problem led to job conflict, and over 15% indicated that their problem resulted in absenteeism.

With regard to years of service, those who had worked for 10 to 19 years had the highest participation rate in the EAP program. As well, the 36 to 45 age group used EAP almost twice as much as the 46 to 55 age group.

Health and Social Services System Corporate Plan

Mission, Vision, Principles and Goals

MISSION

The mission of the health and social services system is to promote, protect and improve the health and independence of Islanders.

VISION

One system of quality services that promote health and independence through relationships based on trust and shared responsibility.

PRINCIPLES

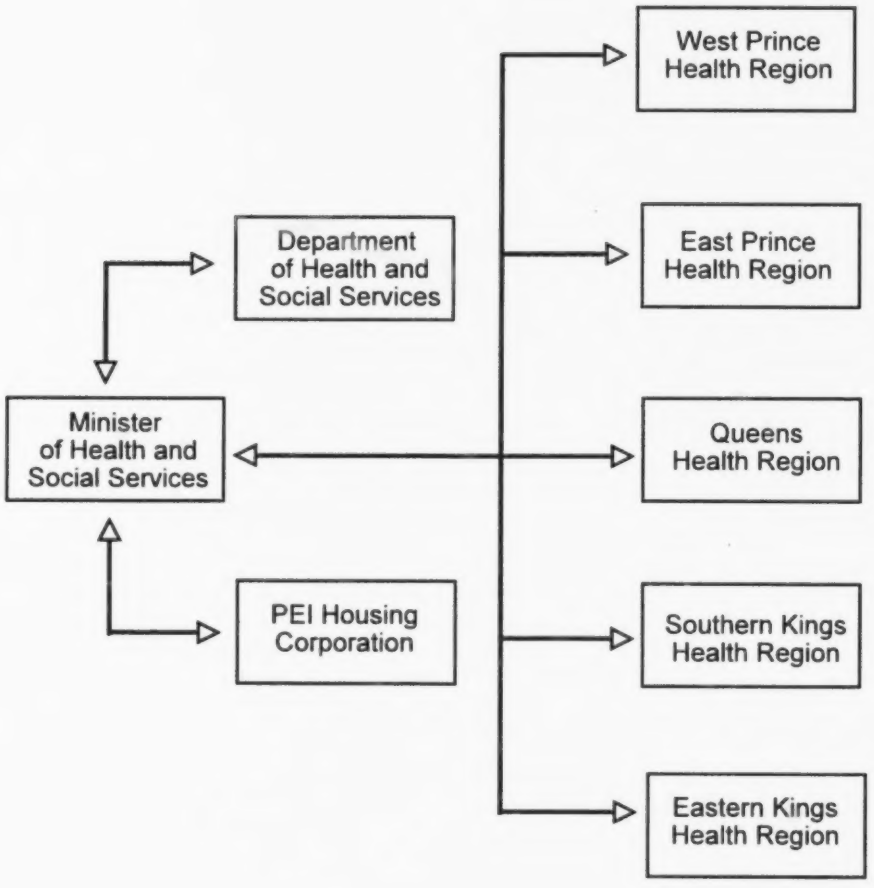
Wellness	~	Our primary focus will be on wellness and children's health.
Sustainability	~	We will allocate resources appropriately to respond to changing needs and ensure continued access to quality programs and services.
Accountability	~	We will measure and report on our performance and health outcomes.

GOALS

- Improve the health status of Islanders
- Increase our acceptance of responsibility for our own health
- Improve the sustainability of the system
- Increase public confidence in the system
- Improve workplace wellness and staff morale
- Maintain other results at current levels

Health and Social Services System Organizational Structure

Prince Edward Island
as at March 31, 2002


West Prince Health Region
East Prince Health Region
Queens Health Region
Southern Kings Health Region
Eastern Kings Health Region
Department of Health and Social Services
Minister of Health and Social Services
PEI Housing Corporation

Minister's Role and Responsibilities

The Minister of Health and Social Services is accountable to the Legislature of Prince Edward Island for the quality of the health and social services system in the province and its impact on the health and well-being of Islanders. The Minister develops system-wide strategies, plans and policy direction in consultation with Regional Health Authorities and carries the interest of RHA's and citizens to Executive Council and the Legislature. The Minister allocates resources to Health Authorities in a fair and equitable manner and monitors and reports to the public on system performance and results.

The Minister of Health and Social Services is responsible for achieving acceptable results in Prince Edward Island in the following areas:

Jointly with individual citizens, families, communities, regional health authorities, physicians, other provincial government departments, non-government health care providers and health organizations:

- Health of citizens
- Individual, family and community acceptance of responsibility for health
- Impact of the physical and social environment on health of citizens
- Independence of citizens with physical, intellectual and financial disabilities
- The quality of housing in the province
- The quality of public policy affecting health of citizens
- Sustainability of the provincial health and social services system

Jointly with regional health authorities, physicians and health care providers:

- Quality of services and their impact on citizens
- Cost-effectiveness of health and social services
- Patient, family and client satisfaction
- Equitable access to health care and social services
- Health, safety and dignity of those under care
- Workplace wellness and morale of provincial and regional health care and social services providers and staff
- Occupational health and safety of staff and volunteers
- Public confidence in the health and social services system

And is responsible for:

- Quality and performance of provincial and regional health care and social service providers and staff and their conduct of health business
- Physician / health care provider confidence in the PEI health and social services system
- Relations with other governments, stakeholders and agencies
- Quality of monitoring of health outcomes and health and social services system performance
- Condition of health and social services system facilities and equipment

- Condition of health and social services system finances
- Compliance with government legislation and regulations
- Enforcement of assigned legislation and regulations

Such other responsibilities and obligations which are from time to time assigned by the Legislature and Executive Council

Deputy Minister's Role and Responsibilities

The role of the Department of Health and Social Services is to provide leadership in innovation and continuous improvement across the Health and Social Services System; and to provide specific high quality administration and regulatory services to the Health System and to Islanders.

The Deputy Minister of Health and Social Services is responsible for achieving acceptable results in Prince Edward Island in the following areas:

1. Quality* of advice, assistance, information and leadership provided to the Minister, and as appropriate, to regional health authorities and their staff, public and private health care providers, in the areas of:

- Policy formulation and implementation
- Development and adoption of outcome standards
- Monitoring health outcomes and status
- Frameworks and processes for planning
- Resource allocation
- Capital project planning
- Communications strategies
- Human resource planning and development
- Information technology system planning
- Issues management
- Development and interpretation of legislation, regulations and compliance
- Interacting with other governments and their processes
- Dissemination of research knowledge and comparative data
- All areas defined by the "Health and Social Services Mission"

And is responsible for:

2. Quality of administration and operation of direct service in:

- Registration, premium collection, disbursement to providers, and other physician payment services
- Out-of-province health service procurement and payment
- TB, STD and communicable disease control
- Ambulance services contracts and associated policies
- Blood services contracts
- Information technology systems
- Adoptions and post adoption consultation
- Provincial Non-Government Organizations (NGO) contracts
- Autism programming
- Health information resources

3. Quality of health and social services legislation and enforcement of legislation and regulations assigned to the department

4. Quality of monitoring of health outcomes provincially and regionally within the province

5. Client and provider satisfaction

6. Influence on decisions as appropriate of other governments, departments and agencies affecting health

7. Quality of relationships with other governments, Regional Health Authorities (RHAs) and their staff, departments, agencies, associations, suppliers and contractors, etc.

8. Quality, performance, morale and conduct of staff and their occupational health and safety

9. Public confidence in the health and social services system

10. Costs and cost effectiveness

11. Condition of Department finances and assets

12. Departmental adherence to legislation and government policy

13. Such other duties and obligations that are from time to time required by the Minister

* Quality is defined by reliability, usefulness, quantity, timelines, cost, attitudes and confidentiality (when called for).

Regional Health Authority Boards Role and Responsibilities

In 1993 five Regional Health Authorities (West Prince, East Prince, Queens Region, Southern Kings and Eastern Kings) were established as part of the provincial health and social services system. Directly accountable to the Minister of Health and Social Services, each health authority is governed by a local Board of Directors who has the mandate to deliver health and social services to the region for which they are responsible. These services include: addictions; child and family services (financial assistance and support services programs); community mental health; dental; home care and support; hospitals; housing; manors; pharmacy; public health nursing; and environmental health.

The role of the Regional Health Board is to define the strategic plan for the Health Region within the context of the Provincial Strategic Plan; assess and report on health status and health needs of the population being served; monitor and report on Health System Performance and impact on Health outcomes, fiscal condition and morale and performance of CEO/staff; and collaborate with other community agencies which influence determinants of health of their citizens and provide advice to the Minister on matters pertaining to the Health and Social Services System.

The Board of the Regional Health Authority is responsible for achieving acceptable results in its region in the following areas:

Jointly with citizens, families, communities, physicians, other provincial government departments, and non-government health care providers and health and social services organizations:

- Health of citizens of the region
- Individual, family and community acceptance of responsibility for health
- Impact of the physical and social environment on health of citizens
- Independence of citizens with physical, intellectual and financial disabilities
- The quality of housing in the region
- The quality of public policy affecting health in the region
- Sustainability of the regional health and social services system

Jointly with physicians and health care providers:

- Quality of health and social services and their impact on citizens
- Cost effectiveness of health and social services
- Patient, family and client satisfaction
- Equitable access to health and social services
- Health, safety and dignity of those under care
- Public confidence in health care and social services in the region

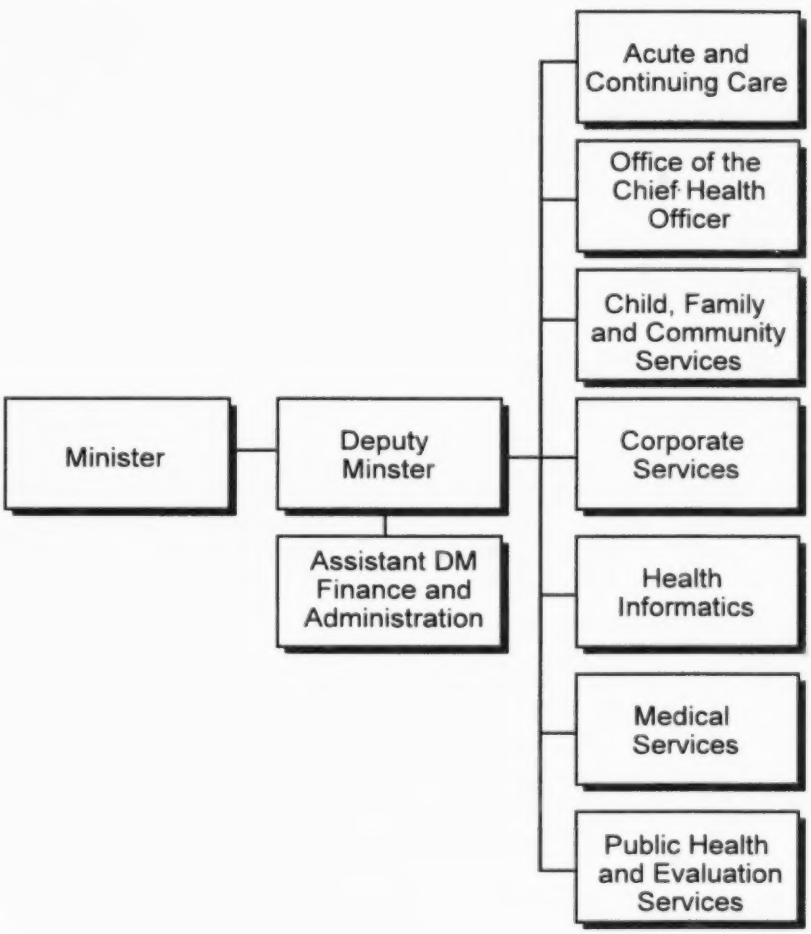
And is responsible for:

- Workplace wellness and morale of RHA health and social services staff
- Quality and performance of RHA health and social services staff in their conduct of RHA business
- Workplace health and safety of regional staff and volunteers
- Physician / health care / social services provider confidence in RHA
- Relations with other RHAs, Department of Health and Social Services, stakeholders and government and non-government agencies inside and outside of the province
- Quality of monitoring of health outcomes and health and social services system performance
- Condition of RHA facilities and equipment
- Condition of RHA finances
- Compliance with government legislation and regulations
- Enforcement of assigned legislation and regulations

Such other responsibilities and obligations which are agreed to by the Minister and the boards

Department of Health and Social Services Organizational Structure

Prince Edward Island
as at March 31, 2002



Roles of Divisions

ACUTE AND CONTINUING CARE

The Acute and Continuing Care Division is responsible for the quality of advice and assistance provided to the Minister, and Health Regions in policy and program development, innovation and continuous improvement in the following service areas: acute; continuing and home care; in-province and out-of-province hospital services; medical technology assessment; ground ambulance and emergency air evacuation; blood services; adult protection; seniors policy; dialysis; and drug programs.

OFFICE OF THE CHIEF HEALTH OFFICER

The role of the Chief Health Officer is to administer and enforce the Public Health Act and Regulations; supervise and direct immunization programs, communicable and other disease control measures; and coordinate chronic disease surveillance and related research projects. The Office of the Chief Health Officer is responsible for reducing public health risk to individuals, families and committees by carrying out regulatory functions in the following areas: communicable disease control (including 50 notifiable diseases); treatment of water for human consumption; safety and health associated with swimming pools; standards for slaughter houses, food establishments and facilities producing food for human consumption; control of epidemics; immunization guidelines and programs; standards for milk and milk products; inspection of buildings and facilities such as daycares; and provision of personal services involving piercing, penetration or tattooing of the skin.

CHILD, FAMILY AND COMMUNITY SERVICES

The Child, Family and Community Services Division is responsible for the quality of advice and assistance provided to the Minister and the Health Regions in policy and program development, innovation and continuous improvement in the following service areas: Addictions, Adoptions, Child Protection, Disability Support, Early Childhood Services, Emergency Health and Social Services, Employment Enhancement and Job Training, Family Support Orders, Financial Assistance, Healthy Child Development, Housing, Mental Health, Youth.

CORPORATE SERVICES

The Corporate Services Division is responsible for the quality of advice and assistance to the Minister, Department staff and Regions in the following areas: strategic and operational planning; corporate policy development; human resources planning; legislative support; records management; French language services; Health System Corporate Relations; and Federal - Provincial relations.

MEDICAL SERVICES

The Medical Services Division is responsible for the quality of advice and assistance to the Minister, Health Regions, and Department staff in the following areas: physician resource planning and recruitment; medicare program administration; medical policy; and program innovation and improvement. The Division also has responsibility for developing effective partnerships between physicians and others in the health care delivery system.

FINANCE AND ADMINISTRATION

The Finance and Administration Division is responsible for the quality of advice and assistance provided to the Minister, Department Directors and staff; and Regions in the following areas: budgeting and financial management; financial and administrative policy; capital projects; risk management; budget preparation, monitoring and forecasting; processing of department expenditures; revenue management; financial planning and analysis; auditing and investigation services; and managing the administrative requirements associated with the Housing Corporation Act. The Division works closely with departmental managers and the health authorities to provide advice and support on financial and administrative matters.

HEALTH INFORMATICS

The Health Informatics Division is responsible for the quality of planning, design, implementation and operations of information technology and information management solutions for the Prince Edward Island Health System, in collaboration with the Health Authorities and Department clients; and within the corporate IT strategy of the provincial health system and provincial government. This includes health information systems and communications technology policy formulation, health information systems security, confidentiality and privacy protocols; information needs, development and adoption of operating standards for health information systems; and issues management relevant to the Division. The Division also has responsibility for operation of the Office of Vital Statistics. The Director of Health Informatics also shares responsibility for all phases of planning, development, design and construction of the new East Prince Health Facility.

PUBLIC HEALTH AND EVALUATION SERVICES

The Public Health and Evaluation Division provides support and provincial leadership in the areas of health promotion, health protection, chronic disease and injury prevention, chronic disease surveillance and related projects and healthy public policy. The Division also supports the health and social services system with program evaluation and research initiatives to ensure the measurement and reporting of system performance and outcomes.

The Division is responsible for the quality of advice and assistance provided to the Minister and Health Regions in the following areas: public health; community nutrition; diabetes services; environmental health; dental public health; children's dental care; reproductive care; cervical cancer; breastfeeding; HIV/AIDS; tobacco reduction; access to credible health information; healthy public policy; health education; social marketing; program evaluation; results measurement; and the PEI Health Research Program and health research. The Division also includes an Epidemiology component which carries out research on communicable disease and non-communicable disease issues.

Regional Health Authority Board Members

as at March 31, 2002

Eastern Kings Health Region

Weston W. Rose, Chair
Marian Trowbridge, Vice Chair
Henry Compton
Peter F. MacAdam
Mary MacPhee
Freda McKie
James McCabe

Chief Executive Officer - Mark MacPherson

Southern Kings Health Region

Michael Gallant, Chair
David White, Vice Chair
Thomas Carver
June Glover
Sherry Kacsmarik
Thelma MacLeod
Sandra Myers

Chief Executive Officer - Betty Fraser

Prince Edward Island Health Regions

Population by Region - 2001

West Prince	14,600	(10.5%)
East Prince	33,608	(24.3%)
Queens	68,447	(49.4%)
Southern Kings	14,501	(10.5%)
Eastern Kings	7,357	(5.3%)

West Prince Health Region

Robbie Thibodeau, Chair
Ernest Hudson, Vice Chair
Barry Clohossy
Juanita Gaudet
Harry MacAusland
Donald Stewart
Richard Wightman

Chief Executive Officer - Ken Ezeard

East Prince Health Region

Dr. Allen MacLean, Chair
Barry Murray, Vice Chair
Stewart Affleck
Henri Gallant
Doreen Gunn
Blanche Maynard
Carol Peters
Gertrude Trainor
Elmer Williams

Chief Executive Officer - David Riley

Queens Region

Sylvia Poirier, Chair
Leon Loucks, Vice Chair
Dr. Don Clark
Kristen Connor
William Fitzpatrick
Judy Gillis
Dr. Bob Johnson
Doug MacDonald
Dr. David McKenna

Chief Executive Officer - Sylvia Barron

Legislative Responsibilities

Legislation administered by the Health and Social Services System for which the Minister of Health and Social Services is responsible:

1. Adoption Act
2. Adult Protection Act
3. Change of Name Act
4. Child Care Facilities Act
5. Chiropractic Act
6. Community Care Facilities and Nursing Homes Act
7. Consent to Treatment and Health Care Directives Act
8. Dental Profession Act
9. Dietitians Act
10. Dispensing Opticians Act
11. Donation of Food Act
12. Drug Cost Assistance Act
13. Family and Child Services Act
14. Health and Community Services Act
15. Health Services Payment Act
16. Hospital and Diagnostic Services Insurance Act
17. Hospitals Act
18. Housing Corporation Act
19. Human Tissue Donation Act
20. Licensed Nursing Assistants Act
21. Marriage Act
22. Medical Act
23. Mental Health Act
24. Nurses Act
25. Occupational Therapists Act
26. Optometry Act
27. Pharmacy Act
28. Physiotherapy Act
29. Premarital Health Examination Act
30. Provincial Health Number Act
31. Psychologists Act
32. Public Health Act
33. Rehabilitation of Disabled Persons Act
34. Social Work Act
35. Tobacco Sales to Minors Act
36. Vital Statistics Act
37. Welfare Assistance Act
38. White Cane Act

NOTE: Two other statutes that are private members Bills are not in the Province's Official Consolidation but are considered to be within the responsibility of the Health and Social Services Ministry:

- Dental Technicians Association Act
- Funeral Directors and Embalmers Act

Program Profiles

The Health and Social Services System is committed to being accountable to the public by measuring and reporting results in two major areas: system performance; and health outcomes.

The following Program Profiles present the current and planned system performance indicators including those that measure how well the programs perform (program performance) and those that measure the impact that programs have on clients' health (client outcomes). The System is also collecting information on the health status of the PEI population including such measures as life expectancy, infant mortality, quality of life, burden of illness, and chronic diseases, which will be reported on in the future. These measures will give a picture of how healthy Islanders are, although it may not be possible to tell how much of this is due to the Health and Social Services System because health is determined by many other factors as well, such as income, education and early childhood experience.

With regard to the information provided in the Resources components of the Program Profiles the following should be noted:

HUMAN RESOURCES

The number indicated on staff dedicated to a program is the approximate full-time equivalency and unless indicated otherwise is the combined total of health region and department staff.

FINANCIAL RESOURCES

The expenditure amounts are rounded off to the nearest thousand dollars.

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Acute Care Services

PROGRAM DESCRIPTION:

PEI has two referral hospitals (Queen Elizabeth Hospital and Prince County Hospital) and five community hospitals (Kings County Memorial Hospital, Souris Hospital, Western Hospital, Community Hospital, and Stewart Memorial Hospital). In addition, a number of acute care services are accessed by Island residents through out-of-province hospitals.

GOVERNANCE / ACCOUNTABILITY:

The Regional Health Authorities are responsible for managing and delivering acute services.

RESOURCES:

FISCAL YEAR	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)				
Queen Elizabeth Hospital	986	1,000	1,031	1,036
Prince County Hospital	341	360	373	379
Kings County Memorial H	71	83	85	83
Western Hospital	57	57	59	60
Community Hospital	57	62	68	66
Souris Hospital	56	63	65	62
Stewart Memorial Hospital	28	33	33	32
TOTAL	1,596	1,658	1,714	1,718
FINANCIAL	$99,035,000	$102,406,000	$106,406,000	$112,198,000

PROGRAM PERFORMANCE:

Current and planned measures

- Number of hospital beds
- Number of in-patient admissions and in-patient days
- Average length of stay
- Number of births (includes births in out-of-province hospitals)
- Number of emergency room/out-patient visits
- Wait times in Emergency Departments
- Number of surgeries (in-patient and out-patient)
- Most common reasons for hospitalization
- Hospitalization rates of ambulatory sensitive conditions
- Total hip replacement and total knee replacement rate
- Wait time for hip replacement and knee replacement
- 30 day in-patient mortality rate for heart attack and stroke
- Rate of patient management instructions given at discharge for heart failure
- Rate of blood cultures taken before treatment for pneumonia
- Pneumonia screen or pneumococcal vaccination rate
- Patent/client satisfaction
- Staff satisfaction

CLIENT OUTCOMES:

Current and planned measures

- Unscheduled re-admissions for heart failure, pneumonia, heart attack and gastrointestinal bleed.

SOME RESULTS:

Hospital Bed Numbers by Year	1998-99	1999-00	2000-01	2001-02
Queen Elizabeth Hospital	274	274	274	274
Prince County Hospital	112	112	112	112
Kings County Memorial Hospital	30	30	30	30
Souris Hospital	17	17	17	17
Western Hospital	27	27	27	27
Community Hospital	10	10	10	10
Stewart Memorial	4	4	4	4
Total (In-Province)	474	474	474	474
Total (Out-Of-Province)*	50	42	31**	28**
TOTAL	524	516	505	504
Bed to Population Ratio	3.8	3.8	3.7	3.6

* *Represents bed equivalency.*

** *2000/01 and 2001/02 bed equivalency excludes 3,224 and 5,142 days respectively in lodges, hostels and alcohol/drug rehabilitation programs. Previous years include these days.*

- 49% of in-patient days were used by patients aged 65+ years and over at the Queen Elizabeth Hospital and Prince County Hospitals.
- 66-76% of in-patient days were used by patients aged 65 years and over at community hospitals.

In Province Hospital Data By Year	1998-99	1999-00	2000-01	2001-02
Number of In-patient Admissions	18,148	17,796	18,280	16,409
Number of In-patient Days	144,189	148,473	140,716	133,395
Average Length of Stay	8	8	8	8
Number of Births (includes births in out-of-province hospitals)	1,566	1,546	1,385	1,356
Number of Newborn Days	5,570	5,570	5,280	5,439
Average Length of Stay (Newborns)	4	4	4	4
Number of Emergency Room/Out-patient Visits	125,062	126,696	136,681	143,694
Number of In-patient Surgeries	5,235	4,852	4,743	4,689
Number of Out-patient Surgeries	5,911	6,303	6,212	5,573

MOST COMMON REASONS FOR HOSPITALIZATION* 2001 - 2002			
By Number of Cases		By Total Hospital Days Used	
1. Gastrointestinal/Digestive Disease	982	1. Other Factors (Convalescence, Aftercare)	5,016
2. Newborns (>2500 grams)	877	2. Gastrointestinal/Digestive Disease	4,819
3. Childbirths (vaginal delivery)	599	3. Stroke	4,468
4. Simple Pneumonia/Pleurisy	497	4. Simple Pneumonia/Pleurisy	4,436
5. Heart Failure	361	5. Heart Failure	4,210
6. Gynecological Procedures	345	6. Depressive Mood	4,146

Data Source: PEI Discharge Abstract Database
** Data based on Case Mix Groups*

Addiction Services

PROGRAM DESCRIPTION:

Addiction Services provides assessment, counselling, in-patient and out-patient detoxification, early intervention programs, rehabilitation, aftercare, public education, family support, and adolescent programs, as well as in-patient and out-patient gambling addictions programs.

GOVERNANCE / ACCOUNTABILITY:

The provincial addictions treatment facility provides services including: in-patient detox, addictions counselling for clients and families, gambling and women's programs and in-patient rehabilitation to all persons in the province. In each of the health regions, services such as out-patient detox, family counselling, smoking cessation and student assistance programs are offered. The Department works with addiction partners to develop policies, standards, programs, coordination and public awareness on addiction issues.

RESOURCES:

FISCAL YEAR	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)	88	106	109	113
FINANCIAL	$ 3,988,000	$ 4,545,000	$ 5,603,000	$ 5,901,000

PROGRAM PERFORMANCE:

Current and planned measures

- Number of clients using programs (In-patient & Out-patient Detox, Out-patient Rehabilitation, Gambling, Women's, Youth, Smoking Cessation and Family Counseling)
- In-Patient occupancy rates
- Re-admission rates
- Wait times for admission, diagnosis, service and follow-up care
- Length of follow-up and level of community support
- Unit cost of service
- Client satisfaction
- Staff satisfaction

CLIENT OUTCOMES:

Current and planned measures

- Abstinence rates
- Rate of alcohol consumption
- Functional status (ability to function on a daily basis)
- Number of clients able to maintain work and family commitments while receiving treatments
- Number of clients using out-patient programs to make an earlier transition to the community
- Number of clients using early intervention programs compared to the number using in-patient detox

SOME RESULTS:

In-Patient Addiction Beds - Provincial Addiction Facility

CATEGORY	1999	2000	2001	2002
Detox	48	25	25	25
Rehab	16	15	15	15
Shelter	8	6	6	6
Long-Term	37	31	31*	31*
TOTAL	109	77	77	77

* *St. Eleanors House (9 beds) and Talbot House (14 beds) and Lacey House (8 beds). Lacey House will be closing in May 2002. This population will receive treatment temporarily at the Provincial Addictions Treatment Facility in Mt. Herbert.*

In-Patient Detox Admissions by Region - Provincial Addiction Facility

REGION	2000-01*	2001-02	TOTAL
West Prince	68	107	175
East Prince	134	197	331
Queens	543	771	1,315
Southern Kings	76	105	179
Eastern Kings	45	95	140
Other		31	31
TOTAL	866	1,306	2,171

* *Admissions for 2000-01 are from the opening date of the Provincial Addiction Facility on November 11, 2000 to the end of the fiscal year, March 31, 2001.*

Admissions to In-Patient Programs by Region, 2001-2002 - Provincial Addiction Facility

REGION	MALE	FEMALE	TOTAL
West Prince	94	13	107
East Prince	165	32	197
Queens	615	156	771
Southern Kings	91	14	105
Eastern Kings	84	11	95
Other	26	5	31
TOTAL	1,075	231	1,306

Admissions to Out-Patient Programs by Region, 2001-2002

REGION	DETOX[1]		REHAB		FAMILY SERVICES		ADOLESCENT SERVICES		OTHERS		TOTAL
	M	F	M	F	M	F	M	F	M	F	
West Prince	117	79	73	16	5	29	30	18	113	103	583
East Prince	207	70	372	64	7	70	79	42	n/a	n/a	911
Queens	108	54	231	162	7	52	89		75	121	899
Southern Kings	81	71	163	91	0	80	46	87	1	16	636
TOTAL	513	274	839	333	19	231	199	192	189	240	3,029

[1] *includes alcohol and other drugs, gambling and tobacco*

Adoption Services

PROGRAM DESCRIPTION:

Adoption Services recruits adoptive families for Island children in need of alternative family situations. The program monitors private sector adoptions to ensure they comply with legislated standards. In addition, assistance is given to people with international adoptions. A client service for adult adoptees and birth families who seek information and/or reunions is also provided.

GOVERNANCE / ACCOUNTABILITY:

Delivered by the Department, Adoption Services works in partnership with the health regions regarding moving children to adoption and supervising and supporting adoption placements.

RESOURCES:

FISCAL YEAR	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)	9.5	9.5	9.5	9.5
FINANCIAL	*Program funded under the overall budget for Child Protection Services.*			

PROGRAM PERFORMANCE:

Current and planned measures

- Number of Adoptions (including private and international adoptions)
- Number of new applications for Post Adoptive Services
- Number of Matches
- Number of successful adoptive placements
- Rate of placement for children with adoptive needs
- Wait times for assessment and placement for children with adoptive needs
- Number of Permanent Wards adopted
- Number of applicants and approved families for adoptions
- Number of inquiries for adoptions (including private and international adoptions)

CLIENT OUTCOMES:

Current and planned measures

- Positive outcomes for Children in Care who are adopted

SOME RESULTS:

- Increase in the number of Permanent Wards adopted
- Increase in the number of applicants and approved families for adoptions
- Decrease in the wait time for assessment of adoptive applicants, especially for Queens Region
- Increasingly difficult to find families willing to adopt children with special needs without an ongoing supported adoption program (New PEI Supported Adoption Program will be implemented in 2003).
- Increase in the number of active searches for adult adoptees
- Increasing number of inquiries about international adoptions

Number of Adoptions

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
Total	23	29	37	23	24
Private*	17	22	27	16	15
Departmental	5	7	9	6	9
International (Private)	1	0	1	1	1

* *Includes step parent*

New Applications for Post Adoptive Services

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
New Applications	73	57	83	71	62
Services Provided	118	140	114	64*	156
Active Searches on behalf of Adult Adoptees	48	47	39	23*	64
Matches	7	15	9	6	10

* *Post Adoptive Consultant on medical leave in 2000-01.*

Department Special Needs Adoptions

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
Special Needs Adoption	4	5	5	5	5

Permanent Ward Adoptions

Decade	1980 - 1989	1990 - 1999
Avg Number of Low Risk Infant Adoptions per Year	9	4
Avg Number of Special Needs Adoptions per Year	9	5
Total Numbers of Permanent Ward Adoptions	175	90

Ambulance Services - Air Ambulance

PROGRAM DESCRIPTION:

Emergency air evacuation services are contracted/purchased from New Brunswick Air Care and Nova Scotia Emergency Health Services. At a cost from $6,500 to $11,000 per transfer, this is a comprehensive service to be requested by physicians only when patients meet criteria for critical transfer.

GOVERNANCE / ACCOUNTABILITY:

This service is monitored by the Department, based on standards and performance criteria established in Memorandum of Agreements with the provinces of Nova Scotia and New Brunswick.

RESOURCES:

FISCAL YEAR	1998-99	1999-00	2000-01	2001-02
FINANCIAL	$ 497,000	$ 380,000	$ 580,000	$ 502,000

PROGRAM PERFORMANCE:

Current and planned measures

- Number of air ambulance transfers
- Compliance with response time and flight time standards
- Compliance with qualification and training standards for aircraft personnel
- Compliance with Flight Safety Program

SOME RESULTS:

AIR AMBULANCE TRANSFERS	1998-99	1999-00	2000-01	2001-02
N.B. Air Care	8	3	7	6
Nova Scotia EHS	41	39	48	47
TOTAL	49	42	55	53

MONITORING OF PERFORMANCE STANDARDS:

A number of performance standards are monitored through the contracts between the Department of Health and Social Services and air ambulance providers, including:

(a) compliance with response time and flight time standards;
(b) compliance with qualification and training standards for aircraft personnel;
(c) compliance with Flight Safety Program.

Acceptable standards are being achieved in all areas.

Ambulance Services - Ground Ambulance

PROGRAM DESCRIPTION:

Ground Ambulance 24 hour, 7 days per week, pre-hospital emergency services are provided by five private operators.

GOVERNANCE / ACCOUNTABILITY:

Subsidization to private operators is provided through the PEI Ambulance Assistance Program which is administered by the Department. The Emergency Medical Services Board licenses and monitors the service to ensure compliance with legislated standards and regulations.

RESOURCES:

FISCAL YEAR	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)*	0.7	0.7	0.7	0.7
FINANCIAL	$ 1,699,000	$ 1,852,000	$ 2,887,000	$ 3,152,000

* *Department only*

PROGRAM PERFORMANCE:

Current and planned measures

- Number of calls to Ambulance Services (including out of province transports)
- Number of out of province transports
- Number of repatriations (returns to PEI)
- Wait time from receiving call to ambulance leaving, en route to the scene
- Compliance with patient care protocols
- Compliance with Ambulance Vehicle Maintenance Program
- Completeness of Call Report Forms and Incident Reports
- Patient Satisfaction

SOME RESULTS:

- The number of calls to ambulance services has increased by 33% since 1998-99
- The number of out of province transports has increased by 54.5% since 1998-99

Breakdown of calls by ambulance service

AMBULANCE SERVICE	1998-99	1999-00	2000-01	2001-02
Neils	2,909	2,708	3,297	3,991
Royal	1,655	1,788	2,042	2,271
Rooneys	725	911	790	953
West Prince	661	643	764	852
Kings County EMS	1,334	1,411	1,597	1,647
TOTAL	7,284	7,461	8,490	9,714

Out of province ambulance transports[1]

AMBULANCE TRANSPORTS	1998-99	1999-00	2000-01[2]	2001-02
Transports from PEI to Out of Province Hospitals	226	225	332	406
Repatriations Back to PEI	178	195	187	218
TOTAL	404	420	519	624

[1] *Out of Province Transports are included in the Total Calls identified in the above table*
[2] *Out of Province Medical Transport Support Program was established effective April 1, 2000*

MONITORING OF PERFORMANCE STANDARDS:

The Ambulance Service Performance Based Contract defines standards related to operational practices and service quality. Operators are adjusting well to new performance requirements with good compliance in all areas including:

(a) Wait time from receiving call to ambulance leaving, en route to the scene
(b) Patient care protocols
(c) Ambulance Vehicle Maintenance Program
(d) Completeness of Call Report Forms and Incident Reports

An Ambulance Service Patient Satisfaction Survey was conducted in December 2001. Survey results indicate a very high level of satisfaction with ground ambulance services.

- 94% of respondents ranked their overall experience with the ambulance services as either excellent" or "good".
- All other questions designed to measure satisfaction (such as prompt arrival, clean, well-equipped and supplied ambulances, professional staff appearance, courteous behaviour of staff, respect for privacy, being kept informed, and explaining interventions) received similar high satisfaction scores.
- All five ambulance services met the contract performance standard of 90% satisfaction with services provided.

Child Protection Services

PROGRAM DESCRIPTION:

Child Protection responds to the need to involve legal processes that aid in the resolution of child protection matters to ensure sensitivity to the developmental needs of the child. The overall goal is to prevent, remove, or lessen the causes of child abuse or neglect.

GOVERNANCE / ACCOUNTABILITY:

The Health Regions are responsible for local operations and delivery of child protection services. The Department has overall administration and enforcement functions including legal and operational support and investigations.

RESOURCES:

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)	58.9*	58.9*	60*	60*	60*
FINANCIAL	$4,090,000**	$4,278,000**	$4,679,000**	$5,149,000**	$7,700,000

* *These positions focus in whole or in part on Child Protection.*

** *Includes departmental budgets, children in care special allowance costs, maintenance of children costs and provincial group home costs.*

PROGRAM PERFORMANCE:

Current and planned measures

- Number of Child Protection files per year
- Number of Children in Care per year
- Number of active cases of Children in Care
- Number of days for Children in Care
- Number of "Children in Need" provided with legal support
- Number of Intake investigations completed within three months
- Number of focussed interventions completed within six months
- Wait time for assessment for Children in Care
- Unit cost of services for Children in Care

CLIENT OUTCOMES:

Current and planned measures

- Functional status for Children in Care

SOME RESULTS:

- Reduction in number of reports requiring child welfare services
- Reduction in percentage of children coming into care relative to number of protection services open
- Reduction in total number of children in care days per child
- Reduction in time between service open and service closed
- Increasing numbers of Child Protection investigations in East Prince and in Queens Region

Child Protection Files by Region

FISCAL YEAR	1998-99	1999-00	2000-01	2001-02
West Prince	117	110	102	41
East Prince	130	144	189	113
Queens	220	293	333	326
Southern Kings	42	39	44	38
Eastern Kings	23	23	19	20
TOTAL	532	609	678	538

Children in Care By Region

FISCAL YEAR	1999-00		2000-01		2001-02	
	CARE DAYS	TOTAL IN CARE	CARE DAYS	TOTAL IN CARE	CARE DAYS	TOTAL IN CARE
West Prince	5,567	28	6,499	30	7,869	35
East Prince	12,241	70	13,216	72	12,466	72
Queens	36,232	174	39,915	175	50,262	182
Southern Kings	7,308	31	8,166	29	8,419	29
Eastern Kings	1,405	10	2,370	11	3,478	11
TOTAL	62,753	313	70,166	317	82,494	329

Legal Case Support (Other than Criminal Code)

CALENDAR YEAR	1997	1998	1999	2000	2001
Clients Represented	37	72	83	72	77

Community Care Facilities

PROGRAM DESCRIPTION:

A Community Care Facility (CCF) is a privately operated licensed establishment with five or more residents. These facilities provide semi-dependent seniors, and semi-independent physically disabled and mentally handicapped adults with accommodation, housekeeping, supervision of daily living activities, meals, and personal care assistance in grooming and hygiene. CCFs receive per diems for residents who require subsidization under the Welfare Assistance Program.

GOVERNANCE / ACCOUNTABILITY:

CCFs are licensed by the Community Care Facilities and Nursing Homes Board. In addition, the Board monitors the facilities for compliance with legislated standards and regulations.

RESOURCES:

FINANCIAL	*This program is funded under the overall Welfare Assistance Program budget.*

PROGRAM PERFORMANCE:

Current and planned measures

- Number of licensed community care facility beds

SOME RESULTS:

- The number of licensed Community Care Facility beds has increased by 17.3% since 1998

LICENSED COMMUNITY CARE BEDS	1998-99	1999-00	2000-01	2001-02
West Prince	91	91	91	91
East Prince	190	243	243	245
Queens	369	379	423	445
Southern Kings	92	92	82	95
Eastern Kings	32	32	32	32
TOTAL	774	837	871	908

Dental Public Health Services

PROGRAM DESCRIPTION:

Dental Public Health (DPH) assists Islanders achieve and maintain good dental health. Depending upon the nature of the treatment the service is provided by either DPH staff or a private dentist. Programs offered are Children's Dental Care Program, Preventive Orthodontic Program, Long Term Care Facilities Dental Program, Early Childhood Dental Initiatives, Cleft Palate Orthodontic Treatment Funding Program, and Pediatric Specialist Services Dental Program.

GOVERNANCE / ACCOUNTABILITY:

Dental Public Health is delivered and administered across the province by the Queens Region Health Authority. The provision and monitoring of services provided by participating private dentists is through program fee guides with the Dental Association of PEI.

RESOURCES:

FISCAL YEAR	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)*	22.8	23.2	24.1	23.4
FINANCIAL	$ 2,075,000	$ 2,106,000	$ 2,256,000	$ 2,301,000

* *Regional only*

PROGRAM PERFORMANCE:

Current and planned measures

- Number of children receiving dental services through Dental Public Health
- Number of children registered with Preventive Orthodontic Clinic
- Number of children treated with orthodontic appliances
- Number of children receiving preventive dental services
- Number of children screened by Early Childhood Dental Programs
- Number of clients screened in long-term care facilities

CLIENT OUTCOMES:

Current and planned measures

- Rates of tooth decay, missing or filled teeth
- Percentage of children who have dental treatment needs

SOME RESULTS:

CATEGORY	1999-00	2000-01	2001-02
Children's Dental Care Program			
Children receiving dental services	17,988	17,482	18,115
Utilization rate, children 3 - 17		69%	73.9%
Average decayed, missing or filled teeth, grade 6 - 7 children		1	0.8
No decay on permanent teeth, children 12 - 13		65%	69.1%
Average decayed, missing or filled teeth, adolescents graduating from CDCP			2.2
No decay on permanent teeth, adolescents			46%
Children receiving preventive dental services	16,869	16,907	15,984
Preventive Orthodontic Clinic			
Children registered	516	513	497
Orthodontic appliances - children treated	287	289	232
Early Childhood Dental Program			
Children screened	600	778	544
Cleft Palate Orthodontic Treatment Funding Program			
Parents receiving funding	11	7	6
Clients screened in long-term care facilities	886	1,002	886

- It is estimated that 4,000 children are seen under third party insurances, raising utilization rates for dental services amongst children 3 - 17 to approximately 90%. This is the highest rate in the country.
- The figures on grade 6 and 7 children, and adolescents graduating from the CDCP, who have not experienced decay on their permanent teeth are equal to or better than anywhere in the country.

Diabetes Program

PROGRAM DESCRIPTION:

The PEI Diabetes Program provides information for Islanders and their families who are living with diabetes. Group education sessions present basic information for those who are newly diagnosed and additional information to help them to develop personal health practices to reduce their risk of developing complications of diabetes. Individual assessments and follow up are also provided. Specialty clinics for gestational diabetes, pediatric diabetes and insulin initiation provide services designed to meet the needs of these specific populations.

GOVERNANCE / ACCOUNTABILITY:

The PEI Diabetes Program adopted a new county governance/delivery model in 2002 that is designed to address current and future increased demands for service, while improving accessibility across the province. In this model, diabetes teams coordinate and deliver diabetes services within their respective regions while maintaining accountability to regional management teams. Provincial diabetes services will be supported by two departmental positions. The Provincial Diabetes Coordinator provides advice, assistance and information to the regional diabetes teams while the Medical Director Diabetes will provide a liaison with primary care physicians.

RESOURCES:

FISCAL YEAR	2000-01	2001-02
HUMAN (FTE)	4.7	8.5
FINANCIAL	$ 253,000	$ 507,000

PROGRAM PERFORMANCE:

Current and planned measures

- Number of programs/clinics by type
- Number of participants in programs/clinics by type
- Number of referrals by region
- Number of patients meeting established clinical targets for metabolic control as outlined by clinical practice guidelines
- Number of individuals with diabetes complications

SOME RESULTS:

Programs/clinics and participants

Program	1999-00	2000-01	2001-02
Pediatric Clinic	2 clinics 15 children diagnosed	5 clinics 12 children diagnosed	6 clinics 12 children diagnosed
Individual gestational diabetes monitoring	Queens Region - 22 clients Summerside - 5 clients	30 clients	21 clients
Insulin education group Program		Queens Region - 5 programs	Queens Region - 4 programs (23 participants)
Getting Started Program	Survival skills were done in the hospital prior to May 2000.	Queens Region - 18 programs - 117 clients - 44 family members	Queens Region - 20 programs - 229 clients
Living Well with Diabetes Course * Note: The Living Well With Diabetes Course is now delivered as modules rather than a 2 day program.	Queens Region - 20 courses - 265 participants Montague - 2 courses - 23 participants Souris - 1 course - 4 participants Summerside - 13 courses - 136 participants O'Leary - 2 courses - 26 participants	Queens Region - 17 courses - 174 participants Montague - 1 course - 10 participants Souris - 1 course - 15 participants Summerside - 16 courses - 162 participants O'Leary - 2 course - 13 participants Lennox Island - 1 course - 9 participants	Queens Region - 24 courses - 259 participants Montague - 1 course - 15 participants Souris - 1 course - 4 participants Summerside - 8 courses - 79 participants O'Leary - 2 courses - 29 participants

Program Referrals

Program Referrals	New Referrals		Re-Referrals	
	2000-01	2001-02	2000-01	2001-02
West Prince	45	43	31	34
East Prince	N/A	179	N/A	123
Queens	290	309	129	261
Southern Kings	39	34	11	32
Eastern Kings	33	36	3	15
Total	407	601	174	465

Disability Support Program

PROGRAM DESCRIPTION:

The PEI Disability Support Program has three main components: employment and vocational services; child disability supports and early intervention; and adult disability supports. Available in all regions across the province the program provides personal care support, early intervention therapy and support for preschool children with autism spectrum disorder, prosthesis and employment support.

GOVERNANCE / ACCOUNTABILITY:

The Department is responsible for the development of program policies, standards and communications of the Disability Support Program, as well as the delivery of the Pre-School Autism Early Intervention Program across the Island. Delivery of all other components of the Disability Support Program is responsibility of the Health Regions.

RESOURCES:

FISCAL YEAR	2001-02
HUMAN (FTE)	21
EXPENDITURE	$1,500,000*

* *The Disability Support Program began on October 1, 2001. Program funding for disability support were previously under financial assistance, family support, EAPD and other programs.*

PROGRAM PERFORMANCE:

Current and planned measures

- Number of people accessing disability supports
- Number of children accessing disability supports
- Number of monitoring and evaluation mechanisms in place
- Number of training processes in place
- Level of client centeredness in service delivery

SOME RESULTS:

DSP Active Services by Region, 2001-2002

Region	West Prince	East Prince	Queens	Southern Kings	Eastern Kings	Total
Services	31	340	356	64	61	852

DSP Active Client Profile by Age, 2001-2002

Age	0-6	7-12	13-18	19-34	34-54	55 plus	Total
No. of Clients*	74	117	91	112	223	74	691

* *This includes spouse or dependants receiving a service.*

DSP Active Client Profile by Gender, 2001-2002

Gender	Female	Male	Total
No. of Clients	307	384	691

DSP Active Client Profile by Disability, 2001-2002

Disability	Physical	Developmental	Mental Illness	Addiction	Total
No. of Clients	153	199	18	7	377

Drug Cost Assistance Program

PROGRAM DESCRIPTION:

These programs provide financial assistance to eligible persons for drug costs, professional pharmaceutical consultation services to clients, government and regional authority institutions and programs and as well, an economical source of medications to the provincial health and social services system. The programs include the Diabetes Control Program, Family Health Benefit Program, Financial Assistance Program, Multiple Sclerosis Drug Program, Seniors Drug Cost Assistance Plan, Nursing Home Program, and Disease Specific Programs.

GOVERNANCE / ACCOUNTABILITY:

The programs are delivered through community retail pharmacies and the Provincial Pharmacy which is operated by, and located within the Queens Health Region. Program delivery by the retail pharmacies is monitored by the Department through service delivery agreements with the PEI Pharmaceutical Association.

RESOURCES:

FISCAL YEAR	1999-00	2000-01	2001-02
HUMAN (FTE)	15.7	13.2	12.2
FINANCIAL			
Diabetes Control Program	$ 597,000	$ 920,000	$ 885,000
Family Health Benefit Program	$ 26,000	$ 56,000	$ 138,000
Financial Assistance Program	$ 2,400,000	$ 3,026,000	$ 3,957,000
Multiple Sclerosis Drug Program	$ 440,000	$ 607,000	$ 661,000
Seniors Drug Cost Assistance Plan	$ 5,678,000	$ 6,630,000	$ 7,199,000
Other Drug Programs	Not Available	$ 2,673,000	$ 2,151,000

PROGRAM PERFORMANCE:

Current and planned measures

For Diabetes Control, Family Health Benefit, Financial Assistance, Multiple Sclerosis Drug and Seniors Drug Cost Assistance Programs:

- Number of clients registered

SOME RESULTS:

DIABETES CONTROL PROGRAM*	2000-01	2001-02
Number of Clients Registered	5,030	5,596
Number of Clients Receiving Benefits	3,836	4,079
Number of Paid Claims	30,396	34,664
Average Number of Claims Per Client	7.92	8.5
Average Cost per Client	$ 223.89	$ 216.92
Average Cost per Claim	$ 28.26	$ 25.52

** Program statistics are not available for the 1999-2000 fiscal year*

FAMILY HEALTH BENEFIT PROGRAM	1999-00	2000-01	2001-02
Number of Clients Registered	560	925	1,477
Number of Clients Receiving Benefits	223	321	792
Number of Paid Claims	977	1,752	5,297
Average Number of Claims per Client	4.38	5.46	6.69
Average Cost per Client	$ 118.38	$ 175.80	$ 173.81
Average Cost per Claim	$ 27.02	$ 32.21	$ 25.98

FINANCIAL ASSISTANCE PROGRAM*	2000-01	2001-02
Number of Clients Registered	12,462	11,628
Number of Clients Receiving Benefits	6,132	6,507
Number of Paid Claims	97,012	131,942
Average Number of Claims Per Client	15.82	20.28
Average Cost per Client	$ 472.39	$ 608.20
Average Cost per Claim	$ 29.86	$ 29.99

** Program statistics are not available for the 1999-2000 fiscal year*

MULTIPLE SCLEROSIS DRUG PROGRAM	1999-00	2000-01	2001-02
Number of Clients Registered	50	75	58
Number of Clients Receiving Benefits	39	53	58
Number of Paid Claims	324	450	547
Average Number of Claims per Client	8.31	8.49	9.43
Average Cost per Client	$ 11,228.00	$ 11,456.08	$ 11,390.87
Average Cost per Claim	$ 1,389.69	$ 1,349.27	$ 1,207.94

SENIORS DRUG COST ASSISTANCE PROGRAM	1999-00	2000-01	2001-02
Number of Clients Registered	19,482	19,629	19,671
Number of Clients Receiving Benefits	12,444	12,955	13,405
Number of Paid Claims	153,210	170,571	180,368
Average Number of Claims per Client	12.31	13.17	13.46
Average Cost per Client	$ 456.05	$ 507.72	$ 537.19
Average Cost per Claim	$ 37.04	$ 38.56	$ 39.91

Early Childhood Services

PROGRAM DESCRIPTION:

The Department through Early Childhood Services supports government, private sector, and community by providing expert advice, and coordination/management of policies and programs for young children. The Department is also responsible for policies and standards development in early childhood initiatives including the Healthy Child Development Strategy. Early Childhood Services delivers the special needs program funding and direct funding grant programs for all licensed early childhood centers as well as the administration of all regulatory and funding programs related to licensed child care centers.

GOVERNANCE / ACCOUNTABILITY:

The Child Care Facilities Board licenses early childhood centers, certifies and is mandated to monitor these facilities for compliance with legislated standards and regulations. The Department in addition to providing resources to the Board to carry out these functions, also delivers the provincial funding programs for licensed centers. The child care subsidy program for Island families is delivered by regional coordinators in the five health regions.

RESOURCES:

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)	6	6	6	6	6
FINANCIAL	$2,692,000*	$3,628,000*	$4,257,000*	$4,403,000*	$4,500,000*

** These expenditures include: Island childcare subsidies, special needs grants, direct funding programs, the operational budgets of the Community Services Section as well as the Child Care Facilities Board. These numbers do not include regional salaries.*

PROGRAM PERFORMANCE:

Current and planned measures

- Number of children enrolled in licensed child care programs
- Number of licensed early childhood spaces
- Number of trained staff working in the field

SOME RESULTS:

Number of Children Enrolled in Early Child Care Programs

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
Children Enrolled	3,968	3,929	4,216	4,220	4,420

Number of Licensed Child Care Programs

Calendar Year	1997	1998	1999	2000	2001	2002
Programs	125	124	124	131	135	133

Number of Licensed Early Childhood Spaces

Fiscal Year	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02
Spaces	3,717	3,994	3,953	4,270	2,786* (4,286)	2,941* (4,608)

** These numbers do not include children in kindergarten programs (1500 in 2001; 1667 in 2002)*

Number of Children Subsidized

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
Children Subsidized	785	1,089	1,166	1,072	1,037

Investments in Child Care Programs

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
Child Care Subsidy	$1,819,000	$2,415,000	$3,085,000	$3,314,000	$3,090,000* (allocation)

Number of Trained Staff Working in Early Childhood Education

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
Trained Staff*	246	255	253	**	281

** Trained staff is defined as certified under the Child Care Facilities Act as "Program Staff"*
***Data not available*

Investments on Children with Special Needs

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
Dollars Spent	$ 447,000	$ 506,000	$ 639,000	$ 783,000	$ 867,000

Environmental Health Services

PROGRAM DESCRIPTION:

Environmental Health assists the Chief Health Officer in carrying out duties and enforcement under the Public Health Act. In addition, Environmental Health promotes and establishes, through education, consultation and inspection, standards consistent with the Act. The inspection programs conducted by Environmental Health includes food safety, rental accommodations, tobacco sales to minors, slaughterhouses, swimming pools, summer trailer courts, tenting and camping areas, and institutional facilities such as day care centres, kindergartens, community care facilities, hospitals, nursing homes and correctional facilities.

GOVERNANCE / ACCOUNTABILITY:

Environmental Health is delivered and managed by the Queens Health Region, and services all health regions in the province.

RESOURCES:

FISCAL YEAR	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)	5.5	6.1	6.2	7
FINANCIAL	$ 330,000	$ 387,000	$ 422,000	$ 427,000

PROGRAM PERFORMANCE:

Current and planned measures

- Number of indoor air quality analyses
- Number of food training courses offered
- Number of inspections (swimming pool, food dispensing establishment, rental accommodation, child care facility and environmental health)
- Number of tobacco legislation compliance checks

CLIENT OUTCOMES:

Current and planned measures

- Incidence of reported food borne illness
- Level of awareness and knowledge regarding safe food handling protocols

SOME RESULTS:

TABLE	1999-00	2000-01	2001-02
Indoor Air Quality Analysis	125	142	80
Food Training Courses	11	11	77
Swimming Pool Inspections	89	87	92
Food Dispensing Establishment Inspections	1,600	1,500	1,500
Rental Accommodation Inspections	65	68	82
Childcare Facility Inspections	134	134	132
Tobacco Compliance Checks	1,559	1,293	1,652
Environmental Health Investigations	330	299	625

Family Housing Program

PROGRAM DESCRIPTION:

This program provides subsidized housing to low and moderate income families who are unable to obtain adequate and affordable accommodation in the private market place. The units, with rents based on 25% of income, are situated in nine communities across the province. Another form of Family Housing is a rent supplement. Rent supplements utilize private market housing to provide accommodations making rents affordable via rent subsidies.

GOVERNANCE / ACCOUNTABILITY:

Under the PEI Housing Corporation, nine local Housing Authorities (community residents appointed by Executive Council) are responsible for day-to-day management of the projects which includes tenant selection, rent collection, and maintenance. Health region staff process applications and provide policy direction and technical support to these Boards.

RESOURCES:

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)*	10.7	10.7	10.7	10.7	9.85
FINANCIAL	$ 2,640,000	$ 2,590,000	$ 2,640,000	$ 2,570,000	$ 2,665,300

** 8.1 of the positions are with the Housing Authorities. The balance of the positions, Regional and Department, also work in part in Seniors Housing.*

PROGRAM PERFORMANCE:

Current and planned measures

- Number of units
- Number of new applications
- Number of placements
- Numbers of families on waiting lists
- Turnover rates

SOME RESULTS:

Family Units

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
Units	479	479	479	479	482*
Placements	77	86	86	67	73
New Applications	328	319	325	290	328
Waiting List	920	850	734	944	547

** This includes 18 rent supplements, 12 in Charlottetown and 6 in Summerside as well as 4 converted units in Crapaud.*

Family Housing Turnover Rate

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
Units Available	16.7%	18.6%	18.6%	14.6%	15.1%

Waiting Lists by Region

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
West Prince	61	59	71	113	59
East Prince	139	167	167	167	80
Queens Region	612	503	390	550	322
Southern Kings	96	106	100	100	75
Eastern Kings	12	15	6	14	11
Total	920	850	734	944	547*

** This number represents a review of waiting list applications.*

Foster Care Services

PROGRAM DESCRIPTION:

The purpose of this program is to ensure there are a range of assessed, trained and supported family homes across the province to provide care to children who are in provincial care through Child Welfare Services. The program contracts with families to meet existing and anticipated housing and care needs for this population.

GOVERNANCE / ACCOUNTABILITY:

The program is delivered by the health regions. The contracted families may be affiliated through regional associations and a Provincial Federation. A Non-Government Service Contract with the Federation is monitored by the Department for compliance. The Director of Child Welfare is responsible for the administration and enforcement of the Foster Care Program.

RESOURCES:

FISCAL YEAR	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)*	21	24	24	24
FINANCIAL	*This program is funded under the overall Child Protection budget*			

** These positions may work in whole or in part with the Foster Care Program.*

PROGRAM PERFORMANCE:

Current and planned measures

- Number of children placed in foster care or kinship care
- Number of foster care homes and new foster care homes
- Length of time to complete assessment Children in Care
- Number of "inactive" foster care families
- Number of children placed in other regions
- Number of families leaving the foster care program
- Number of children with special needs in foster care
- Number of "in care" days
- Unit cost of service for Children in Care

CLIENT OUTCOMES:

Current and planned measures

- Functional status of Children in Care (ability to function in daily life)

SOME RESULTS:

- Decrease in number of available foster homes
- Decrease in number of new families entering foster care
- Increase in number of families leaving regular foster care program
- Increase in number of kinship or relative foster families
- Increase in special needs of Children in Care
- Increase in number of "in care" days

Foster Care Homes By Region

REGION	1999-00	2000-01	2001-02
West Prince	19	17	21
East Prince	33	33	39
Queens	58	73	82
Southern Kings	2	23	3
Eastern Kings	7	6	7
TOTAL	139	152	152*

** The number of Foster Care Homes includes the established homes at year end.*

New Foster Care Homes By Region

REGION	1999-00	2000-01	2001-02
West Prince	6	4	0
East Prince	9	7	10
Queens	6	20	30
Southern Kings	6	4	1
Eastern Kings	2	0	1
TOTAL	29	35	42*

** This number would include only the new cases/homes established. Service changes in 2001-02 made it difficult to accurately track the number of new cases between December 2001 until March 31, 2002.*

Health Information Resource Centre

PROGRAM DESCRIPTION:

The Health Information Resource Centre (HIRC) provides Islanders with free access to reliable and timely information to help them make more informed choices about their health and the health of their families. Information on health topics, disease conditions, and available supports and services is available by visiting the Provincial Centre in Charlottetown or one of the satellite sites across the province, calling the Centre's toll-free number, or through its web site. The Centre also provides Community Access Program and Canadian Health Network services.

GOVERNANCE / ACCOUNTABILITY:

HIRC is a service provided by the Department. The Centre has a Coordinating Committee with representation from users of the service, health professionals, health system, community organizations and the private sector.

RESOURCES:

FISCAL YAR	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)	2	2	3	3
FINANCIAL	$ 99,000	$ 131,000	$ 168,000	$ 169,000
REVENUE		$ 20,000	$ 91,000	$ 148,000

PROGRAM PERFORMANCE:

Current and planned measures

- Number of requests for information
- Client satisfaction

CLIENT OUTCOMES:

Current and planned measures

- Individual use of health information obtained from HIRC

SOME RESULTS:

Requests for Information

FISCAL YEAR	1998-99	1999-00	2000-01	2001-02
Requests for Information	12,000*	15,599	27,204	50,263

** Includes 1047 Provincial Patient Registry calls (Includes walk-in, telephone and Internet Service).*

1997 Survey

- Client satisfaction was high among consumers, health organizations and physicians

Individual used health information obtained from HIRC to:	% of Clients
Increase their knowledge about a particular health issue or problem	87.5
Take care of themselves	56
Learn how to cope with a disease or health problem	56
Raise issues with a health professional	43.7
Help make treatment decisions	37.5
Help take care of someone else who had a health problem	31
Improve lifestyle or prevent a future health problem	25
Understand more about drugs taken	12.5

Home Care Services

PROGRAM DESCRIPTION:

Home Care provides assessment and care planning to medically stable individuals, and defined groups of individuals with specialized needs, who without the support of the formal system, are at risk of being unable to stay in their own home, or are unable to return to their own home from a hospital or other care setting. The PEI Home Care Support Programs include: Home Care Nursing, Community Based Dialysis Program, Visiting Homemakers, Community Support Workers, Occupational Therapy, Physiotherapy, Adult Protection, and Long Term Care Placement. Other services such as Social Work, Nutrition and Speech Therapy may be accessed through regional resources.

GOVERNANCE / ACCOUNTABILITY:

The Health Regions have responsibility for delivery of the programs. The Department is responsible for policy and standards development.

RESOURCES:

FISCAL YEAR	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)	107	107	110	110
FINANCIAL	$ 5,140,000	$ 5,790,000	$ 6,205,000	$ 6,547,000

PROGRAM PERFORMANCE:

Current and planned measures

- Age distribution of clients
- Distribution of Home Care Caseload by Client Type
- Number of Admissions and Discharges
- Average Monthly Caseload by Service
- Number of Nursing and Home Support Visits
- Client satisfaction
- Staff satisfaction
- Admission to public home care services per capita (general and over 75 years old)
- Percentage of population receiving various home care services (e.g. nursing, homemaker, occupational therapy, etc.)

CLIENT OUTCOMES:

Current and planned measures

- Change in functional status for Continuing Care client group (ability to function in daily life)
- Level of symptom control
- Level of care giver burden

SOME RESULTS:

Age Distribution of Clients, 2001-2002

Age Category	0-18	19-39	40-64	65-74	75-79	80+
% Distribution	5.2%	3.9%	14.6%	15.5%	14.3%	46.6%

The senior population represents a significant proportion of the Home Care caseload:

- 46.6% of clients are over age 80
- 61% are over age 75

Distribution of Home Care Caseload by Client Type, 2001-2002

Client Type	% Distribution
Continuing Care (age 65 and over) (ie. Long Term Chronic illness or functional disability)	57.5
Continuing Care (disabled under age 65)	9
Acute Care Substitution and Short Term (ie. IV therapy, complex wound dressings, post surgery care, etc)	22.3
Dialysis Support	2.2
Palliative Care	3
Pediatric	4
Other (mental health, support/follow-up programs)	2

Home Care Admissions and Discharges

FISCAL YEAR	1998-99	1999-00	2000-01	2001-02
Total Home Care Admissions	1,855	1,813	1,903	2,021
Total Admissions age 75 and over	1,119	1,070	1,122	1,127

- The total number of admissions to home care has increased by 9% since 1998-99
- In 2001-02, 61% of admissions were age 75 and over. This is consistent with previous years
- There are approximately 160 admissions and 160 discharges per month; a turnover rate of approximately 10% of the caseload each month.

Average Monthly Caseload by Services

SERVICE	AVERAGE CASELOAD PER MONTH		
FISCAL YEAR	1999-00	2000-01	2001-02
Nursing	903	982	963
Home Support	704	726	649
Occupational Therapy	159	220	268
Physiotherapy	50	39	48
Social Work	N/A	N/A	22
Community Support Worker	87	124	141
Adult Protection	48	49	51
Nutrition	45	22	23
Tele Home Care	0	0	14
Total Caseload	1,996	2,162	2,179

- The average monthly caseload of 2,179 includes individuals who receive services from more than one discipline (approximately 20% of clients). The average number of individual clients per month is 1,757.
- From 1999-00 to 2000-01, the average monthly caseload increased 166 cases or 8.3%.
- From 2000-01 to 2001-02, there was no significant change in monthly caseload.
- The highest proportions of the caseload are in Nursing (45%), Home Support (30%) and Occupations Therapy (12%) services.

Number of Nursing and Home Support Visits

- In 2001-02, there was a total of 40,463 Nursing visits and 63,758 Home Support Visits.
- The ratio of nursing visits to nursing caseload by region ranges from a low of 2.5 per client per month to a high of 5.3 per client per month.
- The ratio of home support visits to home support caseload by region ranges from a low of 6.1 per client per month to a high of 10.3 per client per month.

Home Dialysis Program

PROGRAM DESCRIPTION:

The PEI Home Dialysis Program provides for dialysis treatment in one of two modalities, hemodialysis or peritoneal dialysis. Hemodialysis requires the individual to receive treatment under the direct supervision of a registered nurse and is offered in each of the five regional Home Care sites across the province, and two private residences. Peritoneal dialysis is managed by the individual in their homes with the assistance of family members or other informal caregivers. Support is provided by Home Care nursing for the patient and their family in the area of dressing and tubing changes, teaching and education.

GOVERNANCE / ACCOUNTABILITY:

The Program is under the medical direction of the Nephrology Team of the Queen Elizabeth II Health Sciences Centre in Halifax, Nova Scotia. Delivery of the program is the responsibility of the Regional Health Authorities. The Department is responsible for program administration and has a part-time Coordinator who functions as a provincial liaison between the PEI and NS programs, as well as with the Regional Home Care Managers. A provincial advisory committee has been established to provide advice to senior management of the PEI Health System for a coordinated Renal Program for the province.

RESOURCES:

FISCAL YEAR	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)	N/A	N/A	10.8	10.8
FINANCIAL	$ 649,000*	$ 698,000*	$ 687,000*	$ 734,000*

* *Represents provincial allocations only. Regional Home Care Programs also provide direct service delivery as part of the Regional Home Care budget. The specific breakdown is not available as a separate budget item.*

PROGRAM PERFORMANCE:

- Yearly average number of people receiving hemodialysis and peritoneal dialysis

SOME RESULTS:

Yearly average number of PEI residents receiving dialysis

FISCAL YEAR	1997	1998	1999	2000	2001
Hemodialysis	7	10	14	20	21
Peritoneal	31	24	27	20	20
TOTAL	38	34	41	40	41

Job Creation / Employment Enhancement Programs

PROGRAM DESCRIPTION:

The Job Creation Program (JCP) was designed to assist social assistance recipients to retain or to learn new work skills through short-term employment as they move towards independence. JCP generally provides for a wage subsidy that is cost-shared with the employer. The Employment Enhancement Program (EEP) is intended to assist social assistance recipients by providing work and training opportunities that help remove barriers to employment. This is part of case planning done with the client to assist them in eventually exiting the Financial Assistance Program.

GOVERNANCE / ACCOUNTABILITY:

Delivery of both programs across the province is through the Health Regions. Policies and standards development are the responsibility of the Department.

RESOURCES:

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)	14	14	14	14	14
FINANCIAL	$ 1.4M	$ 1.8M	$ 1.9M	$ 1.8M	$ 1.7M

PROGRAM PERFORMANCE:

Current and planned measures

- Number of clients in Job Creation Program and Employment Enhancement Program placements.

CLIENT OUTCOMES:

Current and planned measures

- Number of clients actively participating in the labour force upon completion of placements.

SOME RESULTS:

JCP and EEP Placements

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
JCP	1,015	1,032	897	822	796
EEP	1,429	1,024	814	1,727	2,021
TOTAL	2,444	2,056	1,711*	2,549	2,817

** This reflects a change in data tracking methods.*

Long Term Care Services

PROGRAM DESCRIPTION:

There are a total of 18 long-term care facilities in the province: nine are privately owned and operated; nine government owned and operated. Individuals who are eligible for nursing home placement are assessed as requiring 24 hour Registered Nurse supervision. Payment for long-term care is the responsibility of the individual. However, when a resident is unable to afford the service, they may apply for financial assistance for subsidization of their cost of care.

GOVERNANCE / ACCOUNTABILITY:

The Community Care Facilities and Nursing Homes Board licenses private nursing homes and is mandated to monitor these facilities for compliance with legislated standards and regulations. The government nursing homes/manors are operated and managed by the Health Regions.

PROGRAM PERFORMANCE:

Current and planned measures

- Number of private and public nursing home beds
- Number of nursing home admissions
- Average number of people on wait list
- Average length of stay in nursing homes
- Average age on admission
- Percentage of nursing home residents receiving subsidy
- Client and family satisfaction

RESOURCES:

FISCAL YEAR	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)	624	666	672	694
FINANCIAL	$ 30,682,000	$ 33,434,000	$35,962,000	$ 37,607,000*

** This total does not include revenue from non-subsidized residents in nursing homes.*

SOME RESULTS:

Private and Public Nursing Home Beds By Region

REGION	1998-99		1999-00		2000-01		2001-02	
	Private	Gov't	Private	Gov't	Private	Gov't	Private	Gov't
West Prince	-	64	-	64	-	64	-	64
East Prince	46	172	46	172	46	172	52	170
Queens	320	208	320	207	320	207	299	222
Southern Kings	31	51	31	51	41	51	41	51
Eastern Kings	-	53	-	52	-	52	-	52
Total	397	548*	397	546*	407	546*	392	559*
Grand Total	945		943		953		951	

Approximately 63% of residents in private nursing homes are subsidized and about 79% of residents in government facilities. Overall, 71-73% of residents are subsidized in long term care at any one time.

** Note: Includes 11 respite beds in Government Nursing Homes.*

Long Term Care Admissions

MEASURE	1998-99	1999-00	2000-01	2001-02
Admissions	380	353	350	345
Average Number of People on Wait List	30	54	41	55
Average Age on Admission	82.6	85.3	82.2	82.8
Average Length of Stay*	2.4 yrs	2.5 yrs	2.7 yrs	2.7 yrs

** These figures represent average length of stay for 96-98% of residents. A small number of residents who have been in long term care for more than 10 years have not been included in the calculation.*

Mental Health Services

PROGRAM DESCRIPTION:

The model for delivery of Mental Health Services places emphasis on a crisis response system, and expansion of community based services which include: initial assessment, education, support, and linkages with other service providers as well as consultation, treatment and ongoing support. In-patient programs are provided at the Prince County Hospital, Queen Elizabeth Hospital and Hillsborough Hospital. Provincial Programs include child psychiatry, psychiatric consultation, and psycho geriatrics for seniors; and an enhanced Children's Mental Health Network for children from birth to eighteen years and their families.

GOVERNANCE / ACCOUNTABILITY:

Mental Health Programs are delivered by the Health Regions and community partners. Community Mental Health programs delivered by the regions are through East Prince (serves West Prince), Queens, and Southern Kings (serves Eastern Kings). In-patient programs are through Prince County Hospital in East Prince (serves West Prince), Queen Elizabeth Hospital in Queens (serves Southern and Eastern Kings as well as all PEI when involuntary admission is necessary), and Hillsborough Hospital in Queens (serves the entire province). The Provincial programs are administered by the Queens Region. The Department provides expert advice, coordination and works with partners to develop policies, standards and public awareness on Mental Health issues.

RESOURCES:

FISCAL YEAR	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)*	166.9	166.9	170.9	171.9
FINANCIAL	$10,180,000	$10,206,000	$10,578,200	$ 12,241,700

** These figures do not indicate Psychiatrists under fee for service or contract arrangements.*

PROGRAM PERFORMANCE:

Current and planned measures

- Hospitalization rates by diagnosis
- Number of hospital separations
- Average length of hospital stay
- Percentage of psychiatric separations of all hospital separations
- Number of referrals for depression
- Number of seniors referred
- Number of psychiatric consultations, including the use of the Tele-Health
- Wait times from referral to treatment for Community Mental Health
- Unit cost of service for institutional services
- Client satisfaction
- Staff satisfaction

OUTCOME INDICATORS:

Current and planned measures

- Functional status (ability to function on a daily basis)
- Number of clients able to maintain work and family commitments while receiving treatment
- Number of clients using early intervention programs compared to the number using in-patient facilities
- Change in symptoms for persons with depression
- Change in quality of life for persons with depression
- Unscheduled re-admissions for persons with depression

SOME RESULTS:

- Increase in referrals of moderately mentally ill (i.e. depression, stress disorders, relationship crisis)
- Increased number of younger children being referred to Children's Mental Health services
- Increased public awareness regarding suicides in youth

Out-of-Province Hospital Services

PROGRAM DESCRIPTION:

Each year a number of Islanders access out-of-province hospital services for highly specialized in-patient and out-patient treatments, procedures and consultations. In an effort to keep costs to a minimum, the Department has an Out-of-Province Liaison Service in Halifax, Nova Scotia which assists patients to return to PEI as quickly as medically possible.

GOVERNANCE / ACCOUNTABILITY:

In order to access out-of-province services, prior approval is required from the Department. Physicians may apply, on behalf of their patients, for prior approval in areas of speciality that are not available on PEI.

RESOURCES:

FISCAL YEAR	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)	6	6	6	6
FINANCIAL	$ 14,379,000	$ 13,380,000	$ 13,612,000	$ 14,292,000

PROGRAM PERFORMANCE:

Current and planned measures

- Number of patient days in out-of-province hospitals (in-patient and out-patient)
- Number of patients transferred back to PEI
- In-patient days and costs saved by transferring patients back to PEI
- Patient satisfaction

SOME RESULTS:

Out of Province Liaison Program

FISCAL YEAR	1998-99	1999-00	2000-01	2001-02
Number of Patients Transferred back to PEI	202	203	219	218
In-patient Days Saved	3,066	3,702	3,600	3,600*
Costs Saved	$ 2.42 M	$ 2.79 M	$ 2.88 M	$ 2.88M*

** Estimates as precise numbers are not available due to hospital delays in data reporting.*

Out-of-Province Physician Services

PROGRAM DESCRIPTION:

This program funds the delivery of medical services provided to Island residents by out-of-province physicians. Services provided by visiting specialists at Island sites are also covered through this program.

GOVERNANCE / ACCOUNTABILITY:

This program is administered by the Department and requires prior approval for non-emergency services. Fees are paid at rates approved by the other provinces' Health Care Plans and are billed through the Inter-provincial Reciprocal Billing Agreement. The visiting specialists to the province are paid on a sessional basis.

RESOURCES:

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)	4.2	4.2	4.2	4.2	4.5
FINANCIAL	$ 2,875,000	$ 3,185,000	$ 3,209,000	$ 3,531,000	$ 4,143,000

PROGRAM PERFORMANCE:

Current and planned measures

- Number and type of out-of-province physician referrals
- Number and type of visiting physician specialists

SOME RESULTS:

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
Number of Out-of-Province Referrals	2,361	2,439	2,330	2,724	2,584

- Number of Visiting Specialists: 23 (2 on a casual/relief basis)

Physician Payment Services

PROGRAM DESCRIPTION:

The In-Province Physician Services Program is responsible for the payment of physician services including the administration of various payment modalities.

GOVERNANCE / ACCOUNTABILITY:

The Program is delivered by the Department in consultation with the five Health Regions. Physician numbers are controlled by adherence to regional complements as recommended by the Physician Resource Planning Committee and approved by the Minister.

RESOURCES:

FISCAL YEAR	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)	11.7	11.7	11.7	8.4
FINANCIAL	$ 32,520,000	$ 33,300,000	$ 35,293,000	$ 36,808,000

PROGRAM PERFORMANCE:

Current and planned measures

- Number of approved physician positions
- Number of filled physician positions
- Number of physicians recruited
- Number and type of practice changes by physicians eg. interdisciplinary team approach

Physician Complement

As of March, 2002

	Physician Resource Planning Committee Approved Complement	Filled Positions (Full-time Equivalent)		
	March , 2002	Permanent	Locum	Total
Family Practice	75	69.7	3.1	72.8
Addiction Services	2	1		1
Emergency Room Physicians	9	8		8
SPECIALITIES				
Anaesthesia	9	6	1	7
Dermatology	1	1		1
Internal Medicine	10.2	10.2		10.2
Neurology	1	1		1
Obstetrics/Gynecology	8	7		7
Ophthalmology	4	3.3	0.7	4
Otolaryngology	3	2		2
Pediatrics	7	6		6
Psychiatry	10	10.2		10.2
Surgery: General	7	7		7
Orthopedic	3	3		3
Plastics	2	1		1
Urology	2	2		2
Physical Medicine	1	1		1
*Oncology (Clinical Assoc. 0.6fte)	3.3	3.3		3.3
Radiology	7.6	5.8	1	6.8
Lab. Physicians				
Pathology	4	3		3
Microbiology	1	1		1
Hematology	1			
TOTALS	171.1	152.5	5.8	158.3

* *Includes Medical and Radiation Oncology*

Public Health Nursing Programs

PROGRAM DESCRIPTION:

Public Health Nursing programs are dedicated to the promotion and protection of health and prevention of disease and morbidity. Programs in maternal - child health, school health, communicable disease surveillance and control, and immunization comprise the major contribution of this program.

GOVERNANCE / ACCOUNTABILITY:

Delivery of Public Health Nursing programs is through the Health Regions. Policies and standards development are the joint responsibility of the Department and the Health Region via a provincial Public Health Nursing Coordinating Committee.

RESOURCES:

FISCAL YEAR	1999-00	2000-01	2001-02
HUMAN (FTE)	30.2	31.5	34.1
FINANCIAL	$ 2,112,000	$ 2,269,000	$ 2,524,000

PROGRAM PERFORMANCE:

Current and planned measures

- Breastfeeding rates
- Childhood immunization rates by two years of age
- Attendance and screening results of children at four year old child health assessment
- Unit costs of child health assessments
- Intervals between reportable disease notification and client contact

CLIENT OUTCOMES:

Current and planned measures

- Rates of preschool immunization
- Rates of four year screening attendance
- Rate of breastfeeding
- Incidence of communicable disease follow-up

SOME RESULTS:

- Public Health Nurses visited 1330 newborns and their families in 2000-2001
- 32.1% of pregnant women attended prenatal classes in 1999, up from 26.6% in 1998
- The highest percentage of attendance by age is 15 - 19 year olds (55%)
- In 1999, 25.7% of prenatal women were smokers at delivery, down from 29.3% in 1998

Seniors Citizens Housing Program

PROGRAM DESCRIPTION:

Senior Citizens Housing projects are located in 38 communities across the province and provide apartment style, self-contained rental units to low and moderate income seniors who are unable to meet their housing needs independently. Another form of subsidized housing for seniors is a Garden Suite. These are one bedroom units placed on the property of a host family and when no longer required by the tenant are easily portable to another site. The rent for either form of seniors housing is 30% of income.

GOVERNANCE / ACCOUNTABILITY:

The Health Regions are responsible for the overall management of these properties. The Department is responsible for ensuring the fulfillment of federal-provincial agreements in the housing field and liaison with the federal government.

RESOURCES:

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)*	13.5	13.5	13.5	13.5	13.5
FINANCIAL	$ 6,160,000	$ 6,230,000	$ 6,430,000	$ 6,680,000	$ 6,571,900

* *Some of these positions also work in part in Family Housing. These numbers do not include maintenance of Seniors Housing in East Prince Region as this work is done as part of the overall regional maintenance budget.*

PROGRAM PERFORMANCE:

Current and planned measures

- Number of units
- Number of placements
- Number of new applications
- Number of seniors on waiting lists

SOME RESULTS:

- Incrementally decrease in number of seniors accessing low income supplement programs
- Generally stable vacancy rates across the Island, except in two communities (Kinkora and New London) where chronically high vacancy rates have necessitated a housing needs assessment and options for use will be considered

Seniors Housing

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
Units*	1,176	1,176	1,176	1,176	1,148*
Placements	194	195	172	193	221
New Applications	195	248	206	209	190
Waiting Lists	301	273	297	252	208

* *Portfolio comprised of 1,142 Senior Citizens Units and 6 Garden Suites. The change in 28 units is due to 4 units in Crapaud being turned over to regionally administered family housing and renovations (2 bedroom units, common rooms, etc.) across the Island.*

Social Assistance Program

PROGRAM DESCRIPTION:

Social Assistance has three primary elements: assistance, in cash or services, to those unable to meet their own basic needs (food, clothing, shelter, etc.) or to meet needs due to emergencies; services to help promote or restore self-sufficiency; and services to prevent social dependency.

GOVERNANCE / ACCOUNTABILITY:

Delivery of the Social Assistance Program is through the Health Regions while the Department role is in the area of policy and standards development. The Welfare Assistance Appeals Board (members from across the province appointed by Executive Council) is responsible for reviewing appeals from applicants and beneficiaries.

RESOURCES:

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)				50.5	50.5
FINANCIAL	$ 38.3M	$ 35.9M	$ 31.4M	$ 30.3M	$ 29.4 M

PROGRAM PERFORMANCE:

Current and planned measures

- Change in Social Assistance caseload over time
- Change in Social Assistance expenditures over time

CLIENT OUTCOMES:

Current and planned measures

- Number of Islanders living independently without Social Assistance

SOME RESULTS:

Social Assistance Caseload by Fiscal Year

Fiscal Year	1997-98	1998-99	1999-00	2000-01	2001-02
Caseload size	5,465	5,143	4,668	4,213	4,135
Caseload change	-1.7%	-5.9%	-9.2%	-9.75%	-1.85%
Program Costs	$ 38.3M	$ 35.9M	$ 31.4M	$ 30.3M	$ 29.4M
Cost change	-0.8%	-6.3%	-12.5%	-3.5%	-2.97%

Tobacco Reduction Program

PROGRAM DESCRIPTION:

The PEI Tobacco Reduction Alliance (PETRA) which includes government and non-government organizations was formed in 1999. PETRA is engaged in three types of activities to reduce tobacco use: prevention - help Islanders stay smoke-free; cessation - to encourage and help smokers to stop using tobacco; and protection - to eliminate exposure to second-hand smoke.

GOVERNANCE / ACCOUNTABILITY:

The Department works with community and government PETRA partners to support, implement and evaluate the PEI Tobacco Reduction Strategy including coordination and monitoring of these activities. PETRA member organizations are responsible for the delivery of the programs, some examples include: the PEI Quit Smoking Program and Kick the Nic teen cessation program through the health regions; prevention focused Students Working in Tobacco Can Help (SWITCH) Clubs in high schools by the PEI Division of the Canadian Cancer Society; and staff in both the Eastern School District and the Western School Board and a Smoke Free Homes decal campaign supported by numerous community organizations.

RESOURCES:

FISCAL YEAR	1999-00	2000-01	2001-02
HUMAN (FTE)	1.0*	13.8**	13.8**
FINANCIAL	$ 61,000	$ 100,000	$ 112,000

* *Department only*
** *Includes Addiction Services Nurses*

PROGRAM PERFORMANCE:

Current and planned measures

- Number of program participants
- Client satisfaction
- Number of calls to the toll-free referral line
- Awareness level of teens regarding teen smoking rates and effects of tobacco
- Smoking prevalence rates
- Number of homes where children are exposed to tobacco smoke
- Public opinion rates in support of smoke-free public places

CLIENT OUTCOMES:

Current and planned measures

- Number of cessation program participants who quit smoking at end of program, at three months and at six months
- Number of cessation program participants who reduce their tobacco consumption
- Number of cessation program participants who move along the stages of change continuum

SOME RESULTS:

Kick the Nic Teen Cessation Program 2001-02	130 students enrolled	35% completed program	7.6% quit smoking	over 90% reduced tobacco consumption

PEI Quit Smoking Program, 2001

Participation Rates	Male	Female	Total
Southern Kings	63	83	146
Eastern Kings	43	69	112
Queens	90	122	212
East Prince	75	102	177
West Prince	44	64	108
TOTAL	315 (42%)	440 (58%)	755

Program Success Rate		
Participants Contacted at 3 months	Not Smoking	Reduced to a few cigarettes
209	31%	16%

Smoking Prevalence Rates, 2001
(Canadian Tobacco Use Monitoring Survey (CTUMS) 2001)

Age Group	Prince Edward Island	Canada
Age 15+	25.6%	21.7%
Age 15-19	20.4%	22.5%

Percentage of Homes Where Children Age 0-11 Are Exposed to Tobacco Smoke

Year	2000	2001
Prince Edward Island	25%	26%
Canada	24%	19%

Vital Statistics Program

PROGRAM DESCRIPTION:

The Vital Statistics program is responsible for the collection, registration, maintenance and distribution of vital event information for the Province, this includes: births, deaths, stillbirths, marriages, adoptions, divorces, and legal change of name. The program also provides for the certification/identification of individuals or events, data for statistical and administrative purposes, as well as, legal change of name, issuing marriage licenses and other related duties.

GOVERNANCE / ACCOUNTABILITY:

Provincial program delivered by the Department under the authority of the Vital Statistics Act, Marriage Act, Change of Name Act and has responsibilities under the Child Status Act and the Adoption Act. The program operates under the Division of Health Informatics.

RESOURCES:

FISCAL YEAR	1998-99	1999-00	2000-01	2001-02
HUMAN (FTE)*	5	5	5	5
FINANCIAL	$ 178,000	$ 193,000	$ 208,000	$ 204,000
REVENUE	$213,000	$236,000	$247,000	$283,000

** Department only*

PROGRAM PERFORMANCE:

Current and planned measures

- Improved reporting capability
- Vital Statistics services available at Access Sites
- Improved reporting functionality to Statistics Canada
- Improved security within the program
- Significant maintenance to historical records
- Interface with Common Client Registry (CCR)

CLIENT OUTCOMES:

Current and planned measures

- New information systems have improved the efficiency and effectiveness of ad hoc reporting for client requests
- Improved statistical reporting to the province from Statistics Canada (6-8 weeks compared to two to three years)
- Improved procedures have enhanced the security of information
- Revised legislation has improved program delivery to clients
- Interface with CCR improved the efficience and effectiveness of communication within the health system

Appendix A

OFFICE OF VITAL STATISTICS 2001-02

The Office of Vital Statistics is responsible for the collection, registration, maintenance and dissemination of vital event information for the Province. This includes: births, deaths, marriages, adoptions, divorces, stillbirths, and change of name. The office also issues marriage licenses and registers Clergy for the purpose of performing the marriage ceremony. The Vital Statistics program provides services to the public and a wide variety of stakeholders. Vital event information serves several purposes. For example, the birth registration process is the first official step in a person's right to a legal identity and is the country's first official recognition of a person's existence. Birth Certificates are issued from the registration process and are a primary source of legal identification. They are required by most government and private organizations for such things as determining a person's eligibility for programs, benefits, services and identification for travel outside the country. Vital event data is also required by all levels of government and the private sector for demographic purposes and for effective and efficient public administration. Another significant purpose of Vital Statistics data is that it is used to support a national, and a provincial statistical system, both for population information and health information. This information is used by researchers and health planners in particular, for determining the population's health and necessary health services.

The Vital Statistics office is located in Montague with a branch office in Charlottetown, offering a wide range of services to the public. The collection of registrations is decentralized to 21 population centres. Deputy district registrars forward registrations to the Director of Vital Statistics for verification, processing and permanent filing. Provincial, national and international standards, are required for these procedures as information is provided to Statistics Canada for further processing and reporting to the World Health Organization (WHO) where the data is tabulated and reported worldwide.

The office administers the Vital Statistics Act, as well as the Change of Name Act, the Marriage Act and ensures the effective recording of court orders issued under the Adoption Act and the Child Status Act.

Appendix A (cont'd)

REGISTRATIONS, CERTIFICATES AND OTHER DOCUMENTS PROCESSED BY THE DIVISION OF VITAL STATISTICS

(These figures are based on the calendar year)

REGISTRATION ACCEPTED UNDER THE *VITAL STATISTICS ACT*:

	2000	2001
Birth Registrations	1,416	1,353
Marriage Registrations	973	901
Death Registrations	1,208	1,142
Stillbirth Registrations	4	7
Adoptions Registration	20	31
Divorce Decrees	286	250
Delayed Registrations	6	8
TOTAL REGISTRATIONS RECEIVED	3,913	3,692
*Amendments of birth registration due to marriage	53	n/a
**Amendments/modifications to registrations	5,115	15,462
Changes of name recorded under Change of Name Act	47	46

CERTIFICATES ISSUED UNDER THE *VITAL STATISTICS ACT*:

Birth (short form or wallet size)	5,857	5,877
Birth (long form)	394	427
Marriage	409	400
Death	161	101
Total Certificates	6,821	6,805
Marriage Licenses issued under the Marriage Act	963	902

* Not applicable due to amendment to Vital Statistics Legislation
* Includes amendments to update historical records

Appendix A (cont'd)

VITAL STATISTICS
PRINCE EDWARD ISLAND 1997-2001

	1997	1998	1999	2000	2001
Population	137.2	137,023	137.6	138.1	138.5
Live Births by Residence *	1,591	1,506	1,515	*	*
Rate per 1000	11.6	11	11	*	*
Live Births by Occurrence	1,570	1,476	1,493	1,416	1,353
Rate per 1,000 Population	11.4	10.8	10.8	10.2	9.7
Deaths by Residence	1,030	1,228	1,137	*	*
Rate per 1,000 Population	7.5	9	8.2	*	*
Deaths by Occurrence	1,023	1,164	1,106	1,209	1,142
Rate per 1,000 Population	7.5	8.5	8	8.7	8.2
Natural Population Increase	561	278	378	*	*
Rate per 1,000 Population	4.1	2.02	2.7	*	*
STILLBIRTHS					
20wks TO 27wks gestation**	0	0	0	0	3
Rate per 1,000 births					2.2
28+ weeks gestation	4	3	6	4	4
Rate per 1,000 live births	2.5	2.03	4.01	2.8	2.9
Marriages	876	882	931	973	901
Rate per 1,000 population	6.4	6.4	6.8	7.04	6.5
Divorces	243	309	290	286	250
Rate per 100,000 population	177.1	225.5	210.7	207.09	180.5

Note: Adjustments may be made to last year's Annual Report due to delayed Registrations.

* *Live Births By Residence are not available at this time.*
* *Deaths By Residence are not available at this time.*
* *Natural Population Increase is based on Live Births By Residence and Deaths By Residence.*
***Change from 22 to 20 wks in 1999.*

Appendix B

SOCIAL ASSISTANCE PROGRAM 2001-2002

The Social Assistance Program has as its primary objectives: the provision of services to prevent social dependency, the provision of cash and non-cash benefits to those in need, and the provision of restorative and rehabilitative services to assist in developing increased self-sufficiency.

Attention continues to be focussed upon employability assessments and case plans which may include training, job placements, wage subsidies, job search skills, life skills, literacy training, adult basic education, etc. These interventions, along with the introduction of other support services such as the Family Health Benefit Program, Family Support Orders Program, Enhanced Day Care Subsidies, Employability Assistance for People with Disabilities have all contributed to individuals and families reaching a greater level of independence.

In the past year the rates for the Healthy Child Allowance has increased from $14 per child per month to $38 per child per month. This allowance is designed to enable children to participate in recreational and cultural activities in their communities.

Social Assistance Clients

FISCAL YEAR	1997-98	1998-99	1999-00	2000-01	2001-02
Average Monthly Cases	5,465	5,143	4,668	4,213	4,135
% Change	- 1.7%	- 5.9%	- 9.2%	- 9.75%	-1.85%
Total Program Costs	$ 38.3M	$35.9M	$ 31.4M	$ 30.3M	$ 29.4M
% Change	- 0.8%	- 6.2%	- 12.5%	- 3.5%	-2.97%

FAMILY SUPPORT ORDERS PROGRAM

The Family Support Orders Program provides legal services to clients to help them achieve court ordered agreements for maintenance and child support from non-custodial parents. The results of this service are as follows: ongoing financial aid to clients once they are no longer receiving benefits from the Financial Assistance program, a reduction in benefit levels required while on assistance, and an overall reduction in the number of families requiring assistance on an ongoing basis. During the year 2001, this program directly contributed to 129 families achieving financial independence and a reduction in program expenditures of $ 334,525.

Appendix B (cont'd)

EMPLOYMENT ENHANCEMENT/JOB CREATION PROGRAMS

The Employment Enhancement and Job Creation Programs continue to work closely with Human Resources Development Canada to create opportunities for active participation in the labour force. Greater effort has been focussed upon services to clients with multiple barriers to employment including enhanced assessments of clients needs and referrals to adult basic education programming.

These combined actions contributed to the following results in fiscal year 2001 -2002:

1. A decrease in the Social Assistance caseload of 1.85% (78 cases) from the previous year.
2. A decrease in Social Assistance expenditures of 2.97% from the previous year.
3. An Increase in the number of persons being placed in work situations across the Island (+268).

Job Creation / Employment Enhancement Programs

Fiscal Year	1997 - 1998	1998 - 1999	1999 - 2000	2000 - 2001	2001 - 2002
Placements	2,444	2,056	1,711	2,549	2,817
Expenditures	$ 1.4 M	$ 1.8 M	$ 1.9 M	$ 1.8 M	$ 1.7 M

Appendix B (cont'd)

JOB CREATION/EMPLOYMENT ENHANCEMENT PROGRAMS ACTIVITY BY REGION IN 2001-2002

REGION	NO. OF PLACEMENTS	EXPENDITURES
West Prince		
EEP	41	32,039
EEP- no cost to region	229	-
JCP	52	141,537
Total	322	$ 173,576
East Prince		
EEP	99	20,410
EEP - no cost to region	354	-
JCP	117	175,548
Total	570	$ 195,958
Queens		
EEP	168	64,092
EEP - no cost to region	596	-
JCP	413	951,489
Total	1,177	$ 1,015,581
Southern Kings		
EEP	4	329
EEP - no cost to region	218	-
JCP	133	214,153
Total	355	$ 212,320
Eastern Kings		
EEP	70	15,990
EEP - no cost to region	242	-
JCP	81	128,518
Total	393	$ 144,508
Total	2,817	$ 1,744,105

Appendix B (cont'd)

SOCIAL ASSISTANCE APPEALS BOARD

From April 1, 2001, to March 31, 2002, there were 54 appeals heard. Of the 54 appeals heard, 43 were denied, 11 were granted and 5 were dismissed because of non attendance.

Total expenditures for honorariums, travel, office supplies, telephone and legal was $53,750.

Social Assistance Appeals Board Activity by Region in 2001 - 2002

REGION	APPEALS RECEIVED	APPEALS DENIED	APPEALS GRANTED	*NO SHOWS / DISMISSED
West Prince	0	0	0	0
East Prince	22	18	2	2
Queens	28	20	5	3
Southern Kings	4	1	3	0
Eastern Kings	5	4	1	0
Total	74	47	16	11

** If an appellant does not appear for the hearing, the appeal is dismissed/denied.*

Appendix C

FINANCIAL STATEMENTS

Financial Summary

	2001-2002 Estimates	2001-2002 Actuals	Variance
EXPENDITURES			
Department Management / Services			
Corporate Services	1,573,000	1,486,800	86,200
Office of the Chief Health Officer	452,400	469,200	(16,800)
Medical Services	41,830,200	42,906,000	(1,075,800)
Finance and Administration	8,341,000	7,950,700	390,300
Health Informatics and Vital Statistics	6,205,500	8,990,000	(2,784,500)
Acute and Continuing Care	22,870,400	23,151,100	(280,700)
Public Health and Evaluation Services	2,053,400	1,736,100	317,300
Child, Family and Community Services	7,632,200	5,708,400	1,923,800
Cancer Treatment Centre Expansion/MRI Services	-	212,300	(212,300)
Total Department Management / Services	**90,958,100**	**92,610,600**	**(1,652,500)**
Regionally Delivered Services	**253,909,300**	**257,806,200**	**(3,896,900)**
Total Department of Health and Social Services	**344,867,400**	**350,416,800**	**(5,549,400)**
East Prince Health Facility	**13,000,000**	**20,141,500**	**(7,141,500)**
Total Health and Social Services	**357,867,400**	**370,558,300**	**(12,690,900)**
REVENUES			
Department Management / Services			
Federal	5,185,200	6,040,600	855,400
Licenses and Permits	94,800	77,200	(17,600)
Fees and Services	359,400	796,900	437,500
Sales	104,000	42,700	(61,300)
Investments	700,000	694,700	-5,300
Total Department Management / Services	**6,443,400**	**7,652,100**	**1,208,700**
Regional Revenues	**18,210,700**	**19,007,800**	**797,100**
Total Health and Social Services	**24,654,100**	**26,659,900**	**2,005,800**

Appendix C (cont'd)

FINANCIAL STATEMENTS

Major Program Area Expenditures

	1999/00	2000/01	2001/02
Health Care			
Hospital Services	104,050,100	107,814,200	115,545,200
Physician Services	36,508,700	38,823,600	40,950,600
Blood Services	2,665,000	3,321,600	3,647,400
Ambulance Services	2,232,300	3,467,100	3,654,400
Home Care	5,789,800	6,205,200	6,547,100
Continuing Care	33,434,400	35,961,600	37,607,300
Provincial Pharmacy	12,328,800	14,511,300	16,042,400
Mental Health	10,205,900	10,578,200	12,241,700
Public Health Nursing	2,111,900	2,268,800	2,524,000
Addiction Services	4,544,900	5,603,000	5,901,400
Dental Public Health	2,106,000	2,256,500	2,301,400
East Prince Health Facility	2,244,100	5,894,900	20,141,500
Other Programs	18,877,000	20,735,200	26,858,500
Total Health Care	**237,098,900**	**257,441,200**	**293,962,900**
Social Services			
Child & Family Services	56,844,000	59,253,100	59,176,300
Job Creation	2,329,800	2,236,800	2,278,700
Social Housing	9,178,200	9,268,500	8,932,500
Grants - Non Gov't Organizations	5,101,700	6,100,000	6,207,900
Total Social Services	**73,453,700**	**76,858,400**	**76,595,400**
Total Health & Social Services	**310,552,600**	**334,299,600**	**370,558,300**

Appendix C (cont'd)

FINANCIAL STATEMENTS

Major Programs As A Percentage of Total Budget

	1999/00	2000/01	2001/02
Health Care			
Hospital Services	33.5	32.3	31.2
Physician Services	11.8	11.6	11.1
Blood Services	0.9	1.0	1.0
Ambulance Services	0.7	1.0	1.0
Home Care	1.8	1.9	1.8
Continuing Care	10.8	10.8	10.2
Provincial Pharmacy	4.0	4.3	4.3
Mental Health	3.3	3.2	3.3
Public Health Nursing	0.7	0.7	0.7
Addiction Services	1.5	1.6	1.6
Dental Public Health	0.7	0.7	0.6
East Prince Health Facility	0.7	1.7	5.4
Other Programs	6.0	6.2	7.2
Total Health Care	**76.4**	**77.0**	**79.3**
Social Services			
Child & Family Services	18.3	17.7	16
Job Creation	0.7	0.7	0.6
Social Housing	3.0	2.8	2.4
Grants - Non Gov't Organizations	1.6	1.8	1.6
Total Social Services	**23.6**	**23.0**	**20.7**
Total Health & Social Services	**100.0**	**100.0**	**100.0**